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Refusal to attend school due to separation anxiety and/or school phobia: A Queensland study.

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The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material either in whole or in part, for a degree in this or any other institution.

Signed: .....

(Julia L. Murphy)

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ABSTRACT

In most western countries, the incidence of school refusal has been estimated at 1.7% of the general school-age population. Although this figure indicates that relatively few children suffer from school refusal, numerous articles have been written on the subject. Up until 1980 the ratio of articles was 25 to one compared to articles written about other childhood psychiatric problems. This may be because of the disagreement and confusion that exists about various aspects of school refusal (i.e., aetiological factors, classification, treatment methods) or because no particular theoretical explanation of school refusal has been unanimously accepted by researchers. Separation anxiety, however, appears to predominate as a major causal factor and is present in 75-80% of cases of school refusal.

Researchers at the Harvard Infant Study Laboratory have suggested that separation anxiety (or other of the childhood anxiety disorders) may be preceded by behavioural inhibition. Children may, in fact, have a temperamental quality that predisposes them first to behavioural inhibition followed by separation anxiety. It seems reasonable to assume, therefore, that behaviourally inhibited children could be at-risk for separation anxiety followed by school refusal. If behaviourally inhibited children could be identified at kindergarten/preschool, their transition into Year One (the first year of school) could be eased, and possible school adjustment problems averted.

This project examines the issues mentioned immediately above. Three studies were conducted: Study One, involving 211 Year One children from 12 Brisbane state schools, set a baseline of behaviours against which children in the following two studies could be evaluated; Study Two involved

25 children identified as behaviourally inhibited, and 25 identified as uninhibited, by kindergarten/preschool staff then rated by teachers through to the end of Semester One, Year One; and Study Three involved six children and adolescents who had been treated for school refusal at either the Child and Family Therapy Unit, Brisbane, or the Caboolture Child and Youth Mental Health Service Clinic.

Findings from the studies suggest that the early identification of behaviourally inhibited children by kindergarten/preschool staff could have implications for these children's future school adjustment. Findings also suggest a need for studies to examine behavioural inhibition as a precursor to separation anxiety followed by school refusal.

CHAPTER 1

INTRODUCTION

Attitudes towards the Value of Schooling

Almost 40 years ago Kahn (1958) stated that "education is, in the main, a matter of willing and often enthusiastic co-operation of the three parties - parent, child and school" (p. 337). When education became compulsory in most Western countries in the late 1800s, however, large sections of the population did not value its aims and considered it more important to retain the services or earnings of their young. Laws were enacted that compelled children within a specific age range to attend school and courts were empowered to act if attendance was not regular (Berg, 1991; Kahn, 1958).

Regular school attendance remains a legal requirement and is compulsory in most developed countries for children between ages 6 and 15 years (Berg, 1992; Gray, Smith, & Rutter, 1980; Mitchell & Shepherd, 1980). School/education provides the foundation for children's social and vocational achievement and is generally a matter of great concern to parents and society as a whole. There are both societal and parental expectations that children take advantage of the educational opportunities that are offered (Berg, 1991; Goldberg, 1953; Waller & Eisenberg, 1980).

Parental expectation plays a large role in children's education. Parents may be motivated to provide opportunities that were unavailable to them when they were young or they may be high achievers themselves and expect their children to perform in a similar manner. These parents may have views about the type of schooling they wish their children to obtain and are able to elect either the state or private system.

O'Connor and Fagan (1993) stated that private schools "tend to attract the children of well-to-do parents, usually well educated themselves, or parents who make huge sacrifices to pay the fees" (p. 9). The children of such parents are usually inspired to achieve academically and professionally and gain a large proportion of high end-of-school rankings or grades when compared to peers attending state schools.

However, not all parents and children aspire to, or are capable of, high academic achievement. They seek other qualities in schools, such as their ability to fulfil spiritual, sporting, and/or cultural needs. They may value schools that appear to match their child's temperament, interests, and aspirations, or provide a supportive environment for less capable students. Whatever parents seek in schools, it can usually be found although some parents see no advantage or relevance in education. This minority of parents believe that the economy will never return to its former buoyancy, and unemployment will always remain high. Therefore, they question the importance of their children being compelled to attend school. They encourage them to cease school attendance in order to work and help support the family (Sweetman, 1995; Wigmore, 1982). Parents of low socio-economic status and low achievement and families in which there is domestic violence, mental illness, and drug and alcohol abuse also tend to assign a low priority to school attendance (Absenteeism from Schooling, 1991; Jones, 1980). That children from family situations like those mentioned immediately above should opt out of school rather than opt in, is hardly surprising given the lack of parental interest and support. As a group, these children constitute part of the body of students who absent themselves regularly from school (Fogelman, Tibbenham, & Lambert, 1980; Reynolds, Jones, St Leger, & Murgatroyd, 1980).

General School Absenteeism

Absenteeism is a widespread problem in Western countries. Studies conducted in Australia indicate that absenteeism is a common characteristic of school life. However, the figure quoted by Elburn (1983) over a decade ago of 7% of the total state and private school population absent on any one day in New South Wales, South Australia, and Victoria may be low. The 10% quoted in both a Brisbane and Queensland study is considered more accurate and in line with figures reported in Britain and the United States (Absenteeism from Schooling, 1991; Berg, Butler, Hullin, Smith, & Tyrer, 1978; Hersov, 1985b; Lamble, 1998; Sommer, 1985).

The majority of school absences are justifiable. They are due to physical illness in 75% of cases or to other legitimate causes and are, therefore, excusable (Weitzman, Klerman, Lamb, Menary, & Alpert, 1982). Absences which are insufficiently explained or are not explained at all are generally related to a complex interaction of factors involving the child, home, and school (Absenteeism from Schooling, 1991; Blagg, 1987; Hersov, 1972).

Chronic Absentee Population Groups

Three groups of absentee students have been described in the literature. The first group, school avoidants/withdrawals, are withheld from school for long periods by parents who either condone their absences or fail to enrol them. They are actively or passively encouraged to remain at home to keep the parent/s company, help in the home, or shop for phobic house-bound mothers (Absenteeism from Schooling, 1991; Berg et al., 1985; Blagg, 1987; Hersov, 1972). The second group of school non-attenders are truants. Truants absent themselves (often with other children) without

parental consent. Children classified as chronic truants are absent once a week or more throughout the school year (Berg, 1980a; Berg et al., 1993; Klerman, 1988; Lassers, Nordan, & Bladholm, 1973). School refusers/school phobics constitute the third group. Their non-attendance is attributed to emotional, social, or domestic reasons. They stay at home despite parental persuasion or punishment and pressure from school personnel to attend (Absenteeism from Schooling, 1991; Tyrer & Tyrer, 1974). The two main groups of school non-attenders are truants and school refusals/school phobics (Berg et al., 1993; Pritchard & Butler, 1978; Tyrer & Tyrer, 1974).

Truancy

The clinical distinction between children who truant from school and those who refuse to attend because of anxiety and/or a phobic reaction is relatively clear. Truancy is more prevalent than school refusal/school phobia. It is a behavioural disorder and more of a social problem than an educational one (Blagg, 1987; Fogelman et al., 1980; Tyrer & Tyrer, 1974). Children are scornful rather than frightened of school. They have a potential for delinquency and evidence anti-social behaviour such as lying, stealing, aggression, and destructiveness both in the home and the wider community. Their parents are often rejecting, emotionally depriving, and show little interest in them or their education (Cooper, 1984; Fogelman et al., 1980; Hersov & Berg, 1980; Jenni, 1997; Kahn, Nursten, & Carroll, 1981; Lee & Miltenberger, 1996). There is often familial evidence of marital disharmony, adverse social conditions, and criminal activity. There also appears to be a correlation between truancy, low family income, parental unemployment, and low socioeconomic status (Farrington, 1980; Hersov, 1985b; McRae, 1985; Reynolds et al., 1980; "When Truants," 1982).

Truants come from relatively large families and experience paternal absence in infancy and later childhood. Discipline in the home is inconsistent with parents either setting no limits or exercising excessive punitive control (Farrington, 1980; Hersov, 1985b). Truants change schools frequently, generally under-achieve academically because of lower than average intellectual ability, and have negative perceptions about the relevance and importance of school (Frick, 1964; McRae, 1985; Mitchell & Shepherd, 1980; Reynolds et al., 1980). They have poor peer relationships, identity problems, and defy school authority. Truancy increases with age, is more frequent in boys than girls, and peaks between ages 12 and 15 years (Sommer, 1985).

In contrast, school refusal/school phobia is a neurotic disorder indicative of disturbed family relationships, anxiety at leaving home, and/or fears of school (Elburn, 1983; Hansen, Sanders, Massaro, & Last, 1998; Kearney & Silverman, 1995).

School Refusal/School Phobia

School refusers/school phobics are characteristically overdependent on their mothers, remain in close contact with them, and are shy and fearful of the world outside the home. They have extreme difficulty in attempting to attend school and often complain of nausea, abdominal pain, and headaches. There is an absence of anti-social behaviour (Berry & Lizardi, 1985; Dangerfield, 1984; Fuerst, 1969; Hansen et al., 1998; Radin, 1967; "School Phobia," 1960).

School refusal/school phobia has not been listed as a specific anxiety disorder of childhood or adolescence in any of the Diagnostic and Statistical Manuals of Mental Disorders published by the American Psychiatric

Association. Refusal to attend school, however, is listed as one of the eight diagnostic criteria for separation anxiety disorder in DSM-IV (1994) and is recognised by many researchers as a specific emotional disorder/syndrome affecting up to 1.7% of the school population (Johnson, 1979; Knox, 1989b).

Classification of Terms

There is considerable disagreement among researchers and clinicians about the terms school refusal and school phobia. School refusal, school avoidance, school phobia, and reluctance to go to school have all been used (often interchangeably) by researchers since the early 1940s (Shapiro & Jegede, 1973). Popper (1993) preferred the term school absenteeism as it is more descriptively and etiologically neutral than any of these terms. School absenteeism, however, may be too generic and could be applied to behaviours such as truancy and school avoidance in which there is an absence of any psychiatric diagnosis. According to Kahn et al. (1981) "school refusal is a more inclusive term, since it covers all cases where there is a psychosocial component" (p. 3). Using the term school refusal has merit in that it denotes both excessive fear (phobic reaction) about attending school, and/or anxiety about separation from mother. School refusal, as an outcome of school phobia and/or separation anxiety, will be used throughout this study.

This thesis is divided into seven chapters. Chapter 1 has discussed absentee population groups, differentiated between school refusal and truancy, and defined school refusal/school phobia. Chapter 2 will review literature on the history and clinical presentation of school refusal, and theories of development in childhood anxiety, in particular, separation

anxiety. Chapter 3 will review literature pertaining to the identification, classification, and treatment of school refusal. The rationale for, and outline of, the study will also be presented in Chapter 3.

Chapter 4 will discuss the questionnaires developed and administered in Studies 1, 2, and 3. The results of Study 1 will also be presented in this chapter. Study 2, a study of young children considered to be at-risk for separation anxiety and/or school refusal, will be the focus of Chapter 5. Study 3, case studies of former school refusal children, will be presented in Chapter 6. Information will be sought from mothers in Study 1 and mothers and teachers in Studies 2 and 3 to determine whether it is possible to identify those children with a potential for separation anxiety and/or school refusal. Finally, Chapter 7 will summarise the findings of the study and implications for the early identification of separation anxiety/ school refusal.

CHAPTER 2

AETIOLOGY OF SCHOOL REFUSAL

School refusal has been a controversial subject since it was first noted in the literature. Described as a type of truancy in 1932, it became school phobia in 1941, and separation anxiety in 1956. Although it only occurs in a small number of school-aged children, the ratio of articles on school refusal to other childhood psychiatric problems is high (i.e., 25 to 1 up until 1980) (Graziano, DeGiovanni, & Garcia, 1979; Yule, Hersov, & Treseder, 1980). From the numerous articles available it is obvious that disagreement, and some confusion, still exists about the various aspects of the disorder. This chapter deals with the history, clinical presentation, theories of development, classification of symptoms, and the general lack of consensus among researchers and clinicians about these issues. As noted in Chapter 1, there is disagreement concerning terminology with 71% of studies using the term, school phobia, in preference to school refusal (Kearney & Silverman, 1990). There is even disagreement over the early history of the disorder.

History of School Refusal (First Reported as Truancy)

Jung who, together with Freud and Adler, influenced contemporary psychoanalytic theory and technique, described in "The Theory of Psychoanalysis, 1912" what appears to be a case of school refusal in an 11-year-old girl referred because of school attendance difficulties due to emotional upset. Somatic symptoms such as headaches and nausea were exhibited plus refusal to get out of bed on school mornings. According to Blagg (1987) and Malmquist (1965), Jung reported the case in 1911. Berg (1991) and Crumley (1974) gave the date as 1913.

Later researchers discussed problems in school attendance, in particular persistent school absenteeism, in terms of truancy. The word, truancy, is derived from the old French term for vagrant and means absence from school without proper leave (Broadwin, 1932; Warren, 1948). Broadwin discussed the general problem of truancy in 1932 when he reported two cases which varied from the accepted definition. He described a special, but little known, form of truancy which occurred in children who suffered from a deep-seated obsessional neurosis or an obsessional character disorder. The truancy was part of their general symptomatology and multiplicity of personality difficulties. The disorder corresponds to what is now known as school refusal (Bolman, 1970; Broadwin, 1932; Cooper, 1966a; Ollendick & Mayer, 1984; Waller & Eisenberg, 1980). Broadwin noted children's absence from school to be with, or near to, their mothers and the strong infantile love attachment and hostile attitudes towards them that underlaid their anxiety. He also noted the mothers' excessive concern that interfered with their children's attempts at an independent existence (Atkinson, Quarrington, & Cyr, 1985; Crumley, 1974).

Partridge reviewed the subject of truancy in 1939. Of the four groups of truants identified, the psychoneurotic group were considered to have "inner problems." They had a particularly close emotional bond with their overprotective mothers; fathers were not mentioned in case interpretations. The disturbance in family behaviour was determined by the emotional relationship between mothers and children. The children themselves were obedient, enjoyed school, and were reasonably well-adjusted with no anti-social traits (Blagg, 1987; Estes, Haylett, & Johnson, 1956; Warren, 1948). The symptoms described by Partridge (1939) closely resemble symptoms exhibited by school refusal children diagnosed in more recent times. Apart

from the above mentioned studies little research was undertaken in the area until Johnson, Falstein, Szurek, and Svendsen (1941) differentiated between the more frequent delinquent variety of truancy and the deep-seated psychoneurotic variety which they named school phobia (Cooper, 1966a; Goldberg, 1953; Milman, 1961; Patterson, 1965).

Children with school phobia manifested symptoms of intense fear associated with attending school and could be absent for lengthy periods unless treatment was initiated. Boys and girls between ages 6 and 14 years were affected equally, there were no determining factors regarding ordinal position, and intelligence ranged from low average to superior (Johnson et al., 1941). The most outstanding features of school phobia were: acute anxiety in children when threatened with separation; a noticeable increase in maternal anxiety; and poorly resolved hostile-dependent mother/child relationships (Choi, 1961; Coolidge, Tessman, Waldfogel, & Willer, 1962; Eisenberg, 1958b; Skynner, 1974; van Houten, 1948).

Johnson et al. (1941) presented a theory of school phobia which was psychoanalytically oriented (Kearney & Silverman, 1990; Rubenstein & Hastings, 1980) while Emanuel Klein (1945) suggested three common elements: anxiety, separated into fear of teachers, other children, failure with school work, and separation from mothers; (suppressed) aggression directed by dependent children towards mothers; and secondary gains of exclusive relationships with mothers, manipulation of mothers, and separation of parents (Bolman, 1970; Hitchcock, 1956; Jacobsen, 1948; Thyer & Sowers-Hoag, 1986). Klein (1945) suggested that school phobia was essentially sexual in nature. Children's anxieties, such as the increase in sexual longing or fear of maternal desertion, reactivated the oedipal or pre-oedipal fear of sexual injury to the mother. This resulted in an acute dread

of leaving her to attend school (Eysenck & Rachman, 1965; Malmquist, 1965; Nursten, 1962).

In 1956, Estes et al. declared that school phobia was a misnomer as it emphasised a common symptom of the problem and not its underlying true nature. Children were anxious about leaving mothers rather than frightened of going to school (Goldenberg & Goldenberg, 1970; Gordon & Young, 1976; Johnson, 1957). Estes et al. substituted separation anxiety as a more definitive term for the disorder they described as a pathological emotional state characterised primarily by an intense desire on the part of both mothers and children to be in close physical proximity. The mutually hostile-dependent relationship which led to the need for this closeness was allowed and actually encouraged by mothers (Futterman & Hoffman, 1970; McDonald & Sheperd, 1976; Waldfogel, Coolidge, & Hahn, 1957).

Studies from 1948 to 1960

The majority of early studies on school refusal were conducted in Britain and the United States and consisted largely of case studies that differentiated between school phobia and truancy. Studies from both countries focussed attention on factors in the development of school refusal, characteristics of children, symptoms exhibited, and treatment procedures and outcomes. Considerable agreement was reached between researchers about the following: children's intelligence was average to above; secondary symptoms were present; social class distinction was not obvious; maternal overprotection and hostility were evident; mothers were dependent on their mothers; paternal disinterest and ineffectiveness were pronounced; and precipitating factors such as a recent change of school, birth of a sibling, or family death or sickness had occurred (Hitchcock, 1956; Jacobsen, 1948;

Model & Shepheard, 1958; Morgan, 1959; Suttenfield, 1954; Talbot, 1957). The major areas of disagreement concerned peak age of onset, classification of subtypes, and treatment.

British studies put the peak age of onset at between ages 11 and 13 years (Model & Shepheard, 1958; Morgan, 1959). In the United States, the peak age was variously between ages 5 and 7, 8 and 10, and 11 and 13 years (Rodriguez, Rodriguez, & Eisenberg, 1959; Suttenfield, 1954; Waldfogel et al., 1957).

Two subtypes of children with school refusal were identified. The neurotic group consisted mainly of younger girls who displayed either hysterical or obsessive personality traits. The onset of school refusal was sudden and regarded as an anxiety reaction. The characterological group consisted mainly of older boys in whom indications of widespread character disturbance, such as depression and/or paranoia, were present. The onset of school refusal was gradual and insidious (Coolidge, Hahn, & Peck, 1957; Kearney & Silverman, 1993; King & Ollendick, 1989b). The relevance of classifying school refusal as either neurotic or characterological was questioned, however, by Johnson (1957) who considered that anxiety was the central feature of the disorder. The only variation was in the depth of the problem between mothers and children. Other researchers adopted the concept of subtypes although there was still disagreement about the method of classifying children into specific categories and the actual number of categories identified (De Sousa & De Sousa, 1980; Klungness & Gredler, 1984; Paccione-Dyszlewski & Contessa-Kislus, 1987).

The treatment of school refusal was also a contentious issue, with Klein (1945) being the first researcher to advocate an early return to school. Provided children attended every day, it was relatively unimportant

if they spent time in the principal's office or the classroom (Berryman, 1959; Eisenberg, 1958b; Glaser, 1959). Other researchers believed in the more traditional method of treatment which emphasised removing pressure for attendance, working through dynamic issues until insight was gained, and school reintegration when children and therapists believed they were ready (Coolidge et al., 1957; Rodriguez et al., 1959). Home schooling was not considered an option by the majority of researchers as it was seen as a method of bypassing the problem and removing pressure within the family to change (Eisenberg, 1958a, 1959).

The two most definitive studies and the only two with a statistical basis were undertaken in Britain. Warren (1948) compared school refusal children with a control group of truants, while Hersov (1960a) compared school refusal children with a control group that included both truants and normal children. Children involved in both studies were admitted to in-patient units for treatment. In almost 50% of cases successful school attendance was maintained after discharge.

School Refusal as a Diagnostic Criteria

The first listing of childhood psychiatric disorders appeared in the Diagnostic and Statistical Manual of Mental Disorders (Second Edition) in 1968. Two anxiety disorders - withdrawing reaction and overanxious reaction - were included in a section entitled Behaviour Disorders of Childhood and Adolescence. Major changes were made in DSM-III (1980). A separate diagnostic section called Anxiety Disorders of Childhood or Adolescence was established; separation anxiety disorder was added to overanxious disorder and withdrawing reaction - the latter was renamed avoidant disorder (Last & Beidel, 1991; Mattison, 1992). The first mention of

school phobia also appeared in DSM-III: First, in the index of Diagnostic Terms (School phobia, see separation anxiety disorder), and second, in the general description of separation anxiety disorder where school phobia, a fear of the actual school situation, was differentiated from refusal to attend school because of separation anxiety. "Persistent reluctance or refusal to go to school in order to stay with major attachment figures or at home" was listed for the first time as one of nine diagnostic criteria for separation anxiety disorder (DSM-III, 1980, p. 53). In DSM-III-R (1987) the wording of the diagnostic criteria pertaining to reluctance to attend school and the entry in the Index of Diagnostic Terms stayed the same.

DSM-IV (1994), the most recent APA publication, has omitted school phobia from the Index of Diagnostic Terms. "Persistent reluctance or refusal to go to school or elsewhere because of fear of separation" is listed as one of eight diagnostic criteria for separation anxiety disorder (p. 113). Hence, school refusal/school phobia has not been listed as an anxiety disorder of childhood or adolescence in a DSM publication.

It would appear from the literature that the DSM series is used extensively by researchers and clinicians. It is preferred over the other major series, The International Classification of Diseases (ICD) published by the World Health Organisation, that also deals with emotional problems of childhood and adolescence. In comparing the DSM series to the ICD series Werry (1986) suggested that DSM publications are unique in that they provide necessary and adequate operational criteria for each diagnosis, well documented supporting manuals, and a greater number of categories. Because of the frequency of DSM usage in articles and studies DSM classifications and diagnostic criteria will be used in the present study.

In summary, up until the early 1930s all children who were

persistently absent from school were labelled truants. Later, a form of school absenteeism was called school phobia. Children's fears of school were also explained in terms of fixation at certain levels of psychosexual development, and later again the concept of separation anxiety was introduced.

The above mentioned articles/studies plus the statistically based studies of Warren and Hersov were written and/or undertaken prior to, and including, 1960. They are regarded as seminal articles and are still highly relevant, and frequently cited in school refusal literature.

Confusion still exists about many aspects of school refusal, in particular, diagnostic issues. DSM-III-R and DSM-IV make no reference to school refusal or school phobia as an actual disorder, although, both clearly differentiate between phobic disorders and separation anxiety disorder as emotional disorders of childhood and adolescence.

Clinical Presentation of School Refusal

Children with school refusal usually present with vague complaints about school. This is followed by reluctance to attend and progresses to total refusal to attend or remain at school. Overt signs of anxiety and/or panic are manifested when school attendance is required. Children may also present symptoms of depression (Fuerst, 1969; Hersov, 1972; Marks, 1987).

Anxiety and depression (commonly observed in school refusal children) are important factors in the understanding and subsequent treatment of school refusal (Berg, 1984; Blagg, 1987). Although both disorders share a commonality of symptoms, anxiety disorders are more prevalent and have an earlier age of onset than depressive disorders (Table 2.1) (Bell-Dolan & Wessler, 1994; Kashani & Orvascel, 1990).

Table 2.1

Characteristics of Anxiety and Depression

	Anxiety	Depression
Definition	Non-specific uneasiness in anticipation of internal or external danger	Chronic mood disturbance involving depressed/irritable affect
Psycho-analytic Theory	Response to danger situations in psychosexual phases (mainly oedipal)	Reaction to loss of love object
Learning Theory	Result of neutral stimuli paired with anxiety-provoking response	Learned response to parental (particularly maternal) depression
Children's Temperament	Shy, hesitant, withdrawn in unfamiliar settings	Irritable and negative with irregular eating and sleeping
Maternal Character-istics	Overprotective, anxious, encouraging affection and dependency	Overprotective, preoccupied, irritable, withdrawn, and emotionally distant/rejecting
Symptoms	Avoidance of feared stimuli (school/social interaction), sleep disturbance, somatic complaints, suicidal ideation	Social withdrawal, declining school performance, insomnia, somatic complaints, suicidal ideation or attempts
Age at Onset	Can occur between 15-20 months but generally in preschool years (4-5 years)	Can occur at 4 years, more common between 10 to 11 years escalates during adolescence
Prevalence and Ratio	5% to 10% preadolescents, up to 17% adolescents 2:1 girls to boys High risk of developing anxiety if mother anxious	1% to 10% preadolescents, up to 15% adolescents More common in girls 67% to 70% chance if mother depressed

Compiled from: Carlson & Cantwell (1980); Chapel (1967); Emde (1985); Kearney (1993); Kolvin, Berney, & Bhate (1984); Noyes, Clancy, Crowe, Hoenk, & Slymen (1978); Puig-Antich & Rabinovich (1986); Trautman (1986).

Anxiety Disorders

The most prevalent form of childhood anxiety disorder is separation anxiety (Gittelman, 1986). Of the anxiety disorders, it is more common in school refusal (occurring in 75% to 80% of children) than any other anxiety

disorder (Gittelman & Klein, 1984, 1985; Scott, Cully, & Weissberg, 1995; Thyer & Sowers-Hoag, 1988). Prior to 1994, overanxious and avoidant disorder (Table 2.2) were also considered to be appropriate diagnoses in some cases of school refusal (Bernstein, Garfinkel, & Borchardt, 1990; Houlihan & Jones, 1989; King, Tonge, Heyne, Tinney, & Pritchard, 1994). Definitions of childhood anxiety disorders have changed, however, and only separation anxiety disorder has been retained as a distinct diagnosis in DSM-IV (1994).

Table 2.2

Anxiety Disorders of Childhood and Adolescence

Diagnostic criteria	Year introduced	Incorporated into
	Overanxious disorder	
Generalised persistent anxiety Excessive concern re future events School refusal not a criteria - can be a complication	1980 in DSM-III	Generalised anxiety disorder DSM-IV, 1994
	Avoidant disorder	
Persistent fearfulness of unfamiliar people Social interaction avoided School not avoided but discomfort displayed in school setting	1980 in DSM-III	Social phobia DSM-IV, 1994

Compiled from: Keller et al. (1992); King & Ollendick (1989a); Last (1989); Strauss (1990).

The elimination of overanxious and avoidant disorder causes some difficulty for future studies as the majority of research into anxiety

disorders of childhood and adolescence was undertaken prior to 1994. Data are still highly pertinent and frequently cited, therefore, in the present study overanxious and avoidant disorder are defined separately from separation anxiety (Table 2.3) and discussed where relevant to school refusal.

Table 2.3

Diagnostic Criteria for Separation Anxiety

(1)	recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
(2)	persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
(3)	persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
(4)	persistent reluctance or refusal to go to school or elsewhere because of fear of separation
(5)	persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
(6)	persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
(7)	repeated nightmares involving the theme of separation
(8)	repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated

DSM-IV (1994, p. 113).

Separation anxiety disorder. Separation anxiety is characterised by excessive anxiety and fearfulness on separation from major attachment figures (Mattison, 1992; Ollendick, Lease, & Cooper, 1993; Wachtel & Strauss, 1995). DSM-IV (1994) lists eight diagnostic criteria for separation

anxiety. At least three (or more) criteria must be evidenced, for at least four weeks, for a diagnosis of separation anxiety disorder to be made (Clark, Smith, Neighbors, Skerlec, & Randall, 1994; Irvine, 1997).

Separation anxiety is estimated to occur in approximately 3.5% to 4% of children and young adolescents and may reflect a lifetime vulnerability to develop avoidant behaviours during times of stress (Bernstein & Garfinkel, 1992; Perugi et al., 1988). Mothers may transmit to children trait-like predispositions to develop anxiety. Children may also have a temperamental trait/characteristic that predisposes them to anxiety, in particular, separation anxiety (Biederman, Rosenbaum, Bolduc, Faraone, & Hirshfeld, 1991; Biederman et al., 1993; Hirshfeld et al., 1992; Last & Beidel, 1991).

Temperamental characteristics are considered to be innate and recognisable from birth as the behavioural style or emotional response displayed by children as they interact with, and shape, their environment. Temperamental characteristics manifest early in life, endure over time, are stable, and affect later personality (Biederman et al., 1990; Calkins & Fox, 1992; Garcia Coll, Kagan, & Reznick, 1984; Goldsmith, 1983; Kagan & Snidman, 1991b). The nine temperamental characteristics exhibited by children are: activity level; rhythmicity; adaptability; approach-withdrawal; threshold level; intensity of reaction; quality of mood; distractability; and persistence and attention span. Temperamentally easy or temperamentally difficult children can be identified from the characteristics listed immediately above (Buss & Plomin, 1984; Cowen, Wyman, & Work, 1992; Rowe & Plomin, 1977; Thomas & Chess, 1977).

Temperamentally easy children display opposite characteristics to temperamentally difficult children. As infants, temperamentally easy children are predominantly positive in mood. They approach unfamiliar

people and objects readily and explore unfamiliar situations with ease. They are sociable and outgoing and adapt quickly to environmental change. Their sleeping and eating patterns are rhythmic. They are restful when asleep and contented when awake (Billman & McDevitt, 1980; Carey, 1970; Cowen et al., 1992; Reznick, Gibbons, Johnson, & McDonough, 1989).

Temperamentally difficult children are negative as infants. They are hesitant to interact with unfamiliar people and slow to adapt to both new situations and changes in their routine. Their sleeping and feeding patterns are irregular. They are restless when asleep and irritable when awake. Their temperamental style tends to make them more difficult to care for and affects, and influences, both maternal tolerance and sensitivity, and maternal/child interaction (Campbell, 1989; Carey, 1970; Emde, 1985; Lewis, Dlugokinski, Caputo, & Griffin, 1988; Ricard & Decarie, 1993).

Researchers have suggested that difficult infants have a temperamental quality that predisposes them first to behavioural inhibition followed by separation anxiety (or other of the anxiety disorders) and panic disorder with agoraphobia in the adult years (Biederman et al., 1993; Biederman & Rosenbaum, 1994; Schreier, 1992), or behavioural inhibition followed by separation anxiety, school refusal, and panic disorder with agoraphobia (Deltito & Hahn, 1993; Rosenbaum et al., 1988; Rosenbaum, Biederman, & Gersten, 1989). The temperamental quality of behavioural inhibition may, in fact, be a predisposing characteristic in children at-risk for school adjustment problems throughout their school years (Beeghly, 1986; Biederman et al., 1990; Rosenbaum et al., 1988).

Behaviourally inhibited children are consistently shy, timid, and watchful when exposed to unfamiliar peers and adults, or when in unfamiliar situations. They remain in close proximity to attachment figures, cease

vocalising and playing, and are reluctant to approach - or may actually retreat from - the unfamiliar. This tendency to withdraw or retreat is a relatively enduring trait which may have adverse consequences for their social behaviour at preschool and/or school (Asendorpf, 1991, 1994; Asendorpf & van Aken, 1994; Kagan, Reznick, & Snidman, 1988; Kagan & Snidman, 1991a, 1991b; Plomin & Stocker, 1989; Reznick et al., 1986; Reznick et al., 1989; Rickman & Davidson, 1994; Schmidt et al., 1997).

Researchers conducting ongoing longitudinal studies at the Harvard Infant Study laboratory have found that children who are predisposed to be behaviourally inhibited are irritable as infants and:

* quiet and fearful with a tendency to withdraw from social interaction as toddlers;
* introverted, cautious, and non-interactive with preschool/ kindergarten peers (particularly on the first day); and
* on follow-up at 7 years 6 months still restrained, anxious, and socially timid and/or avoidant at school (Gersten, 1989; Hirshfeld, Biederman, Brody, Faraone, & Rosenbaum, 1997; Rosenbaum, Biederman, Hirshfeld, Bolduc, & Chaloff, 1991; Rosenbaum, Biederman, Hirshfeld, Bolduc, Faraone, et al., 1991).

Approximately two-thirds of behaviourally inhibited children are later - rather than firstborn, while approximately 85% of behaviourally inhibited children have anxiety-prone, overprotective, agoraphobic mothers whose symptoms impinge upon and involve them to a certain degree. Behavioural inhibition in children may elicit protective behaviour from mothers, particularly agoraphobic mothers who are perceived as being intrusive, controlling, and prone to infantilise and encourage dependency in their children (Kagan, Reznick, & Snidman, 1987; Kagan et al., 1988;

Parker, 1979; Rosenbaum et al., 1992; Silove, 1986; Silove, Manicavasagar, Curtis, & Blaszczynski, 1996).

Although the link between behavioural inhibition, separation anxiety, school refusal, and panic disorder with agoraphobia appears to have been first suggested by Rosenbaum et al. in 1988, the link between separation anxiety and panic disorder with agoraphobia has been noted in the literature since the 1960s (Ellis, 1990; Gittelman-Klein & Klein, 1973; Mendel & Klein, 1969; Solyom, Silberfeld, & Solyom, 1976; Torgersen, 1986).

Separation anxiety/school refusal and panic disorder with agoraphobia. Researchers have postulated that the only childhood anxiety disorder that has a relationship to a specific adult disorder is separation anxiety in relation to panic disorder with agoraphobia (Table 2.4). This relationship has been noted in American Psychiatric Association publications since 1980 (DSM-III, 1980; DSM-III-R, 1987; DSM-IV, 1994). A strong familial link exists between the two disorders with maternal panic disorder conferring a threefold risk for separation disorder on children (Casat, Ross, Scardina, Sarno, & Smith, 1987; Raskin, Peeke, Dickman, & Pinsker, 1982; Weissman, Leckman, Merikangas, Gammon, & Prusoff, 1984).

Separation anxiety, like panic disorder with agoraphobia, is characterised by a wide range of avoidant behaviours and active seeking of environments that offer safety, help, and security (Anthony, 1985; Black & Robbins, 1990; Persson & Nordlund, 1985; Perugi et al., 1988; Roth, 1984). Both separation anxiety and panic disorder with agoraphobia respond positively to the drug imipramine which suggests that they share a common emotional factor of disturbance somewhere in the patho-physiological chain

(Ballenger, Carek, Steele, & Cornish-McTighe, 1989; Deltito & Hahn, 1993; Free, Winget, & Whitman, 1993; Kashani et al., 1990; Lesser & Rubin, 1986).

Table 2.4

Similarities between Separation Anxiety and Panic with Agoraphobia

Children	Adults (usually mothers)
React with extreme fear (with morbid thoughts of impending danger) when separated from attachment figures	Experience full-blown panic attacks when unaccompanied by attachment figures in public places
Have difficulty separating from, avoid where possible, separation from attachment figures	Restrict and avoid situations when required to leave an established point of security
Keep open opportunities to reach attachment figures easily and rapidly	Fear unavailabilty of attachment figures when having attacks, avoid places where cannot "escape easily"
Manifest frequent somatic complaints	Present frequently with somatic complaints
Suffer from separation anxiety/ school refusal more frequently than general school-age population if mothers agoraphobic	Have had history of separation anxiety/school refusal in 60% of cases

Compiled from: Berg (1976); Breier, Charney, & Heninger (1986); Casat (1988); Hallam (1978); Nelles & Barlow (1988); Thyer (1986); van der Molen, van den Hout, van Dieren, & Griez (1989); Zitrin & Ross (1988).

Although separation anxiety/school refusal appears to be related to panic disorder with agoraphobia (Deltito & Hahn, 1993; Harris, Noyes, Crowe, & Chaudhry, 1983; King, Tonge et al., 1998; Moreau & Weissman, 1992; Tyrer, 1986; Weissman, 1985), some researchers have suggested that separation anxiety/school refusal is more related to adult neurosis in general (Berg, Marks, McGuire, & Lipsedge, 1974; Marks, 1987; Silove, Manicavasagar, O'Connell, & Blaszczynski, 1993). Notwithstanding the above difference of opinion, fear appears to be a major component in both

conditions. Fear of a specific situation or object that is excessive, persists over time, and causes children significant discomfort and impairment in functioning is customarily referred to as a phobia (Achenbach, 1985; Brulle, McIntyre, & Mills, 1985; Finch & Burks, 1960; Hersov, 1985a; King & Ollendick, 1989a; Ollendick & Francis, 1988).

Phobic disorders. Children may develop either specific or social phobia and either can be present in school refusal (Table 2.5) (King et al., 1994). Specific phobia is more common in the general population, and in both children and adolescents. Social phobia is experienced by adolescents rather than younger children (Beeghly, 1986; Kashani et al., 1990; Ollendick & Francis, 1988). Children suffering from phobic, or other anxiety disorders, may also manifest symptoms of depression (Garber & Kashani, 1991).

Table 2.5

Diagnostic Criteria for Specific and Social Phobia in School Refusal

Specific Phobia (formerly Simple Phobia)	Social Phobia
Persistent irrational fear of particular objects or situations (fear not due to separation anxiety)	Persistent irrational fear that social situations will cause humiliation or embarrassment (fear not due to separation anxiety)
Exposure to phobic stimulus (i.e., school situations) provokes immediate anxiety	Exposure to feared social situations (i.e., academic performance) provokes immediate anxiety
Objects or situations avoided or endured with great anxiety	Social or performance situations avoided or endured with distress
Avoidance, anxious anticipation, distress in feared situations, interferes significantly with academic and social functioning	Avoidant behaviour in feared social or performance situations interferes significantly with academic and social functioning

Compiled from: Clark et al. (1994); Livingston (1991); Strauss (1990); Street & Barlow (1994).

Depression is frequently accompanied by other symptoms and disorders, such as somatic complaints, school refusal, separation anxiety, and panic attacks. The most common co-existing disorder is separation anxiety (Carlson & Cantwell, 1980; Mitchell, McCauley, Burke, & Moss, 1988). Somatic complaints often precede, and mask, separation anxiety and depression, and other of the anxiety and depressive disorders of childhood and adolescence (Bernstein & Garfinkel, 1986; Cytryn & McKnew, 1974; Cytryn, McKnew, & Bunney, 1980; Kuperman & Stewart, 1979; Lesse, 1982; Petti, 1989).

In summary, anxiety and depressive disorders are widely diagnosed in children and adolescents. Researchers have suggested that children at risk for either disorder can be recognised by their temperamental style before they manifest symptoms specific to a particular disorder.

Anxiety disorders appear to be more debilitating for children than depressive disorders with separation anxiety disorder resulting in significant impairment in children's functioning. Both disorders put children at risk for emotional problems in later life.

Anxiety and Depressive Disorders in School Refusal

Anxiety is frequently a symptom of depression while secondary depression is frequently a complication of anxiety. It is difficult to determine which is the primary and secondary disorder as diagnostic characteristics tend to overlap (Hershberg, Carlson, Cantwell, & Strober, 1982; Kearney, 1993; Van Valkenburg, Akiskal, Puzantian, & Rosenthal, 1984). Both disorders occur contemporaneously in school refusal. Researchers have suggested that between 45% and 66% of school refusal children suffer from depression and anxiety concomitantly (Bernstein, 1991;

Kolvin et al., 1984; Kovacs, Gatsonis, Paulauskas, & Richards, 1989; Strauss, Last, Hersen, & Kazdin, 1988). As emotional disorders of childhood and adolescence, both disorders are precipitated by prior circumstances and environmental factors.

Theories of Development in Childhood Anxiety and Depression

Children's temperamental attributes plus environmental factors contribute to the development of childhood anxiety and depression (Willis & Walker, 1989). Other contributing factors include unstable family situations; negative family interactions; inadequate socialisation within the family; and insecure maternal/child relationships (Lewis et al., 1988). The suggestion that insecure maternal/child relationships determine children's later emotional and social functioning was first attributed to Freud and Adler. Their theories (Table 2.6 and Table 2.7) were based on the premise that children's earliest experiences in social bonding and attachment had a persistent and crucial effect on their personality development. Freud and Adler considered that anxiety was a reaction to separation from mothers and a normal developmental phenomenon. Excessive anxiety on separation from mothers was considered to be an indication of conflicts arising from abnormalities and/or inconsistencies within the mother/child relationship (Arlow, 1984; Dare, 1985; Livingston, 1991; Marans & Cohen, 1991; Trautman, 1986).

Freud suggested that children's personalities, relationships with parents (particularly mothers), and behaviour patterns were formed as they passed through various psychosexual stages (Baker, 1985; Dare, 1985; Willis & Walker, 1989). The first three psychosexual phases were of particular importance and dominated by the evolving relationship with

mothers (Austin, 1957; Dare, 1985). Adler focussed on the influence of the family and children's struggle to find significance within the family rather than on sexuality and the Oedipus complex. He suggested that the development of social interest through maternal (in particular) and familial influences was the most important factor in children's emotional development (Dinkmeyer, 1986; Dinkmeyer & Dinkmeyer, 1985; Dinkmeyer, Pew, & Dinkmeyer, 1979; Massey, 1990; Mosak, 1984).

Table 2.6

Psychosexual Stages of Childhood

Phase	Age	Mother/Child Behaviours
Oral	Birth to 18 months	Oral gratification met by maternal involvement and intimate contact
		Beginnings of maternal/child attachment Reassurance by maternal presence - fear and anxiety in absence
Anal	18 months to 3 years	Maternal expectation of children's bodily functions
		Struggle towards independence Conceptualisation of mothers as independent entities - in absence, fear of abandonment
Phallic (Oedipal)	4 to 6 years	Focus on parents of opposite sex - same sex parents seen as rivals for affection
		Inner conflicts manifest in aggression towards both parents

Compiled from: Freud (1920); Gay (1988); Marans & Cohen (1991); Roazen (1984); Rutter & Cox (1985).

Table 2.7

Social Interest in Personality Development

Children's Perceptions	Resulting Behaviours
See themselves as helpless, weak, and lower in status	Strive to attain favoured family positions, try to establish lifestyles of prominence and superiority
Interpret place in family according to birth order (first, second, middle, youngest, only)	Acceptable if social interest properly developed
Feel "deposed" by birth of sibling (i.e., only child becomes older child)	Try to regain place of prominence through unacceptable behaviours

Compiled from: Adler (1924, 1927); Ansbacher & Ansbacher (1956); Chaplin (1975); Dinkmeyer & Dinkmeyer (1985); Dreikurs & Soltz (1964); Manaster (1977); Shulman & Mosak (1977); Stiles & Wilborn (1992); Wilson, (1975).

In the genesis of emotional disorders (in particular, separation anxiety) the conflicts of childhood, mentioned immediately above, are of a critical nature. The theories of Freud and Adler have strongly influenced contemporary psychoanalytic views and contributed to the majority of social development theories of childhood (Arlow, 1984; Dare, 1985) although other influences have been acknowledged as equally important, namely, biological and psychosocial influences (Table 2.8) which determine children's early personality development (Berger, 1985; Willis & Walker, 1989).

Willis and Walker have suggested that "the child's inherited characteristics coupled with the experiences and influences in the child's environment make the child the way he or she is today" (p. 29). The interaction of biological and psychosocial factors also determines maternal/child attachment, and children's subsequent ability to separate appropriately from mothers (Lewis et al., 1988; McGuffin & Gottesman, 1985).

Table 2.8

Child Development Perspectives - Biological and Psychosocial Influences

	Biological Influences
Non-genetic	Effects of maternally ingested toxic substances; premature births; lack of oxygen during birthing process; near fatal accidents in childhood; prolonged/repeated hospitalisation
Genetic	Chromosomal abnormalities; metabolic disorders; strong genetic predispositions for emotional disorders (particularly anxiety and depression)
Temperament	Reaction to environment; behavioural style; emotional reactivity; maternal/child interaction
	Psychosocial Influences
Family	Parental psychopathology (particularly maternal); death or divorce; chronic discord, illness, or repeated separations
Socio-cultural	Parental affection; discipline; modelling of feminine or masculine identification; value systems
Learning	Conditioned positive and/or negative reactions; imitation; rewards and punishment

Compiled from: Berger (1985); Lewis et al. (1988); Rimm & Cunningham (1985); Rutter & Cox (1985); Wilson (1984); Wolkind & Rutter (1985).

Attachment theory. The origins of attachment theory have been attributed to Bowlby and Ainsworth (Table 2.9). Both researchers espoused the theory that specific and enduring mother/child relationships were the result of secure attachment while insecure attachment resulted from maladaptive variations in mother/child behaviours (Bretherton, 1992).

Insecure attachment occurs when mothers deny supportive care-giving interaction, attend to their own needs before their children's, are unavailable, or respond abruptly. Children's instinctive reaction systems are activated and they respond with "anxious attachment" behaviours (Beeghly, 1986; Bowlby, 1960; Calkins & Fox, 1992; Campbell, 1986, 1989; Heard, 1981; Kobak & Sceery, 1988; Tietz, 1970). They fail to complete

separation-individuation, remain emotionally dependent on mothers and, in later years, are prone to developing separation anxiety/school refusal (Goldenberg & Goldenberg, 1970; Gottschall, 1989; Hock & Schirtzinger, 1992; Hoffman, 1984; Kahn & Nursten, 1962; Pollitt, 1984).

Table 2.9

Attachment Theory - Bowlby and Ainsworth

Bowlby
Early establishment of mother/child emotional bonds influences child's later functioning and vulnerability to psychopathology
Emotional bonding/attachment behaviour results in seeking, and/or keeping, close proximity to mother
Child thrives emotionally when mother provides warm, intimate, continuous care - shows distress when mother leaves
Child seeks maternal comfort and closeness when faced with frightening or unfamiliar situations
Ainsworth
Child explores unfamiliar situations when secure mother/child relationships developed - mother serves as base from which child explores
Exploratory behaviour, like attachment behaviour, essential to child's normal development
Distance from mothers increased when attachment secure - when dangers reactivate attachment system, child reestablishes maternal contact
Exploration resumed when mother responds - anxiety expressed when mother does not respond or responds insensitively

Compiled from: Ainsworth (1989); Bowlby (1960); Bretherton (1992); Campbell (1986, 1989); Cooper (1986); Kobak & Sceery (1988); Paterson & Moran (1988); Smith & Pederson (1988).

Separation anxiety can also be manifested by mothers and results from their own insecure attachment history and associative lack of felt security. Mothers meet their need for closeness through their children, overprotect

and infantilise them, prevent independent behaviours, and insist on excessive contact instead of encouraging age-appropriate autonomy (Hock, McBride, & Gnezda, 1989; Hock & Schirtzinger, 1992; McBride & Belsky, 1988; Parker & Lipscombe, 1981). They unconsciously use children as their own attachment figures and regard moves made by them towards emotional maturation as rejection, withdrawal, disloyalty, or loss (Atkinson et al., 1985; Estes et al., 1956; Hock & Schirtzinger, 1989; Parker & Lipscombe, 1981).

Maternal separation anxiety has implications for children's emotional development and maternal mental health, and increases children's risk for depression and separation anxiety/school refusal (Hock & Schirtzinger, 1992).

Separation Anxiety in School Refusal

Although no single theoretical explanation for school refusal has been unanimously accepted by researchers, separation anxiety appears to predominate as a major causal factor. Psychoanalytic theorists advance fear of separation as a central tenet. Psychodynamic theorists suggest fear of failure as a key determinant with separation anxiety as a minor determinant, and learning theorists suggest fear of separation or of school as major causal factors. All disciplines subscribe to the theory that variations in early mother/child relationships contribute to children's vulnerability to develop separation anxiety in school refusal (Atkinson et al., 1985; Heath, 1985; Kelly, 1973; McDonald & Sheperd, 1976).

Psychoanalytic theory of separation anxiety in school refusal.

Children fear school and are reluctant to attend because of extreme anxiety

during separation from mothers. Anxiety is experienced and shared by mothers and precipitated when significant events cause the reemergence of early, unresolved, mutual hostile-dependency (Cooper, 1973; Goldenberg & Goldenberg, 1970; Johnson, 1957; Pollitt, 1984).

Mothers encourage overdependency in children because their own emotional needs are unfulfilled due to unsatisfactory marital relations, feelings of maternal incompetency, unresolved dependency relationships with their own mothers, and a lack of outside interests (Atkinson et al., 1985; Estes et al., 1956; Pilkington & Piersel, 1991; "School Phobia," 1960). The overdependent relationship fosters repressed hostility in both mothers and children. Mothers become hostile because their success in fostering dependence increases children's constant demands upon them and hostile feelings cause guilt and overprotection which are manifested in an inability to set limits on children's demanding behaviours (Buell, 1962; Eisenberg, 1958a; Gordon & Young, 1976). Children become hostile because they unconsciously resent maternal overindulgence which inhibits their ego development in the struggle for individuation and autonomy. Their unconscious destructive thoughts towards their mothers can be so strong that they must remain at home to assure themselves of their safety (Choi, 1961; Dangerfield, 1984; Frick, 1964).

Psychodynamic (or self-concept) theory of separation anxiety in school refusal. Mothers may foster unrealistic self-images in children. By gratifying children's demands, mothers endow them with an unequally large share of power in the family and, at the same time, exaggerate their ability to contend with personal and external demands. As a consequence, children overvalue themselves and their achievements (Coolidge, Willer, Tessman, &

Waldfogel, 1960; Leventhal & Sills, 1964; Leventhal, Weinberger, Stander, & Stearns, 1967; Paige, 1993). They are alert to, and avoid, situations where their preferred self-image is threatened, and when confronted by their limitations become anxious. Because their omnipotent self-estimation is not securely held, they are markedly vulnerable to threat (Bakwin, 1965; Hsia, 1984; Trueman, 1984b; Weinberger, Leventhal, & Beckman, 1973).

Situations at school that challenge children's inflated self-concept result in refusal to attend. They withdraw from competition and stay at home where permissive indulgent mothers reinforce, and maintain, their distorted view of themselves (Bakwin, 1965; Kearney, Eisen, & Silverman, 1995; Radin, 1967).

Learning theory of separation anxiety in school refusal. School refusal is a learned maladaptive response to fear of separation from mothers, or fear of objects, or situations, within the school (De Sousa & De Sousa, 1980; Ollendick & King, 1990). Children's fear of separation is exacerbated and reinforced by undue maternal anxiety about children's safety and frequent maternal threats of abandonment or rejection (Dangerfield, 1984; Pilkington & Piersel, 1991; Sherman & Formanek, 1985). In both cases (overconcern and abandonment), staying at home reduces children's anxiety levels as well as earning secondary gains, such as pleasurable activities and maternal attention (Blagg & Yule, 1984; Greenbaum, 1964; Kelly, 1973; Paige, 1993).

Children who fear school may be traumatised by unpleasant events, such as teasing or bullying. They become frightened of the children responsible then generalise their fear to others. As a result, a major part of their school life invokes extreme anxiety (Doleys & Williams, 1977; Ollendick

& King, 1990, 1998; Pilkington & Peirsel, 1991). Children often exaggerate their fears because they learn that parents (particularly mothers) are sensitive to their problems and respond with attention and affection. Parents may also inadvertently reinforce children's negative comments about school and contribute to their determination to stay home (King & Ollendick, 1989b; Ollendick & Mayer, 1984).

It is also possible that children acquire fears of school through observational learning. If they are in constant contact with peers and/or siblings who exhibit fear of school, or their parents are fearful and anxious about teachers and school situations, children may acquire similar fears. Fears of school may also be intensified by children's academic and social inadequacies (Doll, 1987; Ollendick & King, 1990).

Comparison of theories. Different explanations for the core problem, importance, and precipitants of separation anxiety in school refusal have been suggested by each of the theorists mentioned immediately above.

Core problem of separation anxiety in school refusal:

* Psychoanalytic - children have neurotic fear of leaving mothers because of poorly resolved mother/child dependency relationships;
* Psychodynamic - children fear losing preferred self-image, return to/stay with mothers who foster their unrealistic self-views; and
* Learning - children fear leaving mothers because of maternal overconcern or threats of abandonment (Cherry, 1992; Kearney & Silverman, 1995; Lang, 1982; Veltkamp, 1975).

Importance of separation anxiety in school refusal:

* Psychoanalytic - main contributing factor, children fear losing mothers' love;

* Psychodynamic - contributing factor, (children can successfully attend school for some years before symptom outbreak) mainly fear losing ego; and
* Learning - contributing factor, children also fear objects or situations within school setting (Atkinson et al., 1985; Blagg, 1987; Heath, 1985; Leventhal & Sills, 1964).

Precipitants of separation anxiety in school refusal:

* Psychoanalytic - death of family member/s, recent illness (own or family member/s), change of school, class, and/or district;
* Psychodynamic - people, objects, situations encountered in school setting that challenge children's perceived omnipotence; and
* Learning - non-reinforcing or aversive events in school setting, either social (teasing or bullying) or academic (Berg, 1984; Jackson, 1964; Kearney & Beasley, 1994; King, Ollendick, & Gullone, 1990).

Although separation anxiety is considered to be a contributing factor in school refusal, it may not be the main contributing factor as psychoanalytic theorists have suggested. Children should have problems separating from mothers in all situations (not only to go to school) if separation anxiety was the major causal factor in school refusal. Similarly, the peak incidence of school refusal should occur when children begin preschool or school, not between ages 11 and 12 years as the literature has consistently reported. Neither does the separation anxiety theory as a major causal factor of school refusal espoused by psychoanalytic (and to a lesser degree, psychodynamic) theorists account for only one child within the family being affected by school refusal. If mothers perceive one child as being more vulnerable than another, then a pattern of youngest or only children as school refusers should emerge from studies reported in school

refusal literature (Kearney & Beasley, 1994; Leventhal & Sills, 1964; Pilkington & Piersel, 1991).

It would appear that learning theorists account for all factors involved in school refusal behaviour as they have suggested that school refusal can be the result of a combination of factors such as, mother/child dependency, separation anxiety, or intense fear of people or situations within the school.

School Phobia

A number of researchers contend that school refusal is not a unitary syndrome. It can result from either separation anxiety or a phobic reaction to school (Francis, Last, & Strauss, 1987; Hansen et al., 1998; Kearney, 1995; Last, Hansen, & Franco, 1998; Murray, 1997; Ollendick & King, 1998; Taylor & Adelman, 1990; Werry, 1986). Researchers who subscribe to the latter premise view phobic reaction to school as a distinct disorder which should be differentiated from separation anxiety disorder because of its specificity. In separation anxiety there is excessive fear of separation from attachment figures. In school phobia there is persistent fear of certain stimuli within the school (Burke & Silverman, 1987; Eysenck & Rachman, 1965; Ficula, Gelfand, Richards, & Ulloa, 1983; Hagopian & Slifer, 1993; Sinclair, 1982). According to this theory, school phobia may be identified as a specific, or social, phobia of school (Ollendick & King, 1990; Phelps, Cox, & Bajorek, 1992).

When fear of school centres on circumscribed objects or situations within the school environment (i.e., classrooms, teachers, work presentation), a diagnosis of specific phobia is appropriate. When fear of school centres on social concerns which may involve possible humiliation or embarrassment (i.e., academic or sporting performance), the correct

diagnosis is social phobia (Berg, 1992; Phelps et al., 1992; Wachtel & Strauss, 1995). Diagnostic criteria for specific and social phobias have been presented in Table 2.5.

School phobia is pervasive, difficult to treat, and more likely to present in adolescence than preadolescence (Last & Strauss, 1990). It is not as common as separation anxiety which has been reported as being 2.5 times more prevalent, but can be more disabling: Children with school phobia exhibit higher levels of school refusal behaviour (King et al., 1990; Last, Francis, Hersen, Kazdin, & Strauss, 1987). Parents regard school phobia as more impairing to children, possibly because they do not encourage, or reinforce, contact-seeking behaviour as do parents of children with separation anxiety (Phelps et al., 1992).

Researchers who support a distinction between the two disorders have suggested that school phobia and separation anxiety can be differentiated by gender, age, socioeconomic status, concomitant psychiatric disorders, the presence of school refusal, and maternal psychiatric pathology (Table 2.10) (Frances et al., 1987; Last, Francis et al., 1987; Lee & Miltenberger, 1996). School phobia is a syndrome, not a symptom of school refusal behaviour and can occur without separation anxiety while separation anxiety can occur without a phobic reaction to school (Berg, 1991; Thyer & Sowers-Hoag, 1988). School refusal can result from either disorder and, therefore, can be viewed as a behavioural outcome of separation anxiety or school phobia (Phelps et al., 1992).

The more universally accepted view is of school refusal as "the interplay of two tendencies: avoidance behaviour in relation to school and active seeking of situations providing comfort and security" (Berg, 1991, p. 1093). The terms school refusal and school phobia are often used

interchangeably to denote an emotional problem in children which results in extreme anxiety when faced with attending school (Kearney et al., 1995). Depression frequently co-exists with anxiety and affects a significant number of school refusal children.

Table 2.10

Comparison of Separation Anxiety and School Phobia

Separation Anxiety	School Phobia
Generally prepubertal females, mean age of onset 9.4 years	Generally adolescent males, mean age of onset 14.3 years
Lower socioeconomic backgrounds	Middle-to-upper socioeconomic backgrounds
More severely disturbed, 93% with concurrent disorder	Not as severely disturbed, 63% with concurrent disorder
Main concurrent disorders - over anxious disorder (46%) major depression (31%)	Main concurrent disorders - over anxious disorder (37%) major depression (26%)
Significantly less likely to have school refusal (73%)	Significantly more likely to have school refusal (100%)
Mothers more severely disturbed - generalised anxiety (49%) major depression (86%) and increased prevalence of separation anxiety as children	Mothers not as severely disturbed - generalised anxiety (21%) simple phobia (21%)

Compiled from: Last, Hersen, Kazdin, Francis, & Grubb (1987); Last, Phillips, & Statfield (1987); Last & Strauss (1990).

Depression and Anxiety in School Refusal

The relationship between depression and anxiety in school refusal was noted by Warren in 1948. Later researchers suggested that the basis of school refusal was depressive anxiety, or a manifestation of anxiety and/or underlying depression (Agras, 1959; Campbell, 1955; Kahn & Nursten, 1962; Rabiner & Klein, 1969). Families with a strong history of depressive

illness were more likely to have depressed school refusal children than families without a history of depression (Glaser, 1967; Toolan, 1962). More recent researchers have suggested that childhood depression is equatable with separation anxiety, in particular, of the anxiety disorders. In fact, separation anxiety may be a precursor to adult depression (Gittelman-Klein & Klein, 1980; Mitchell et al., 1988; Puig-Antich & Rabinovich, 1986).

Depression, without separation anxiety, in school refusal is more common in adolescents - it increases threefold from preadolescence to adolescence with girls reporting significantly more symptoms than boys (Bernstein & Garfinkel, 1986; Kashani et al., 1987). Depressed adolescent school refusers are more likely to have suicidal thoughts, make suicidal gestures, or threaten suicide than preadolescent school refusers (Mitchell et al., 1988). However, comparatively few adolescent school refusers - and very few preadolescent school refusers - commit suicide (Agras, 1959; Knox, 1989a). Their emotional upset may also manifest in somatic complaints (Berg, 1991).

Somatic Complaints in School Refusal

The relationship between somatic complaints and school refusal has been reported frequently (Last, 1991). As early as 1941, Johnson et al. suggested that "hypochondriacal symptoms" (p. 703) and "morning sickness complex" (p. 708) were manifested by school phobic children when faced with school attendance.

Children fortify their protests about attending school with a variety of somatic complaints. The complaints may be mild or severe and can be defined as physical symptoms that suggest physical illness (Cerio, 1997; Radin, 1967; Silber, 1982). Because there is no demonstrable organic base

for the symptoms, they are presumed to be psychological in nature and indicative of an underlying emotional disorder (Hersov, 1985b; Nemzer, 1991; Schmitt, 1971). Somatic complaints (e.g., palpitations, nausea, headaches, diarrhoea, anorexia, recurrent abdominal pain) are one of the diagnostic criteria for separation anxiety listed in DSM-IV (Faust & Forehand, 1994; Lall & Lall, 1979; Lesse, 1982; LeUnes & Siemsglusz, 1977; Sperling, 1961; Szyrynski, 1976).

Up to 78% of children with separation anxiety, 50% of preadolescents, and 69% of adolescents with school refusal present somatic complaints. These are more related to anxiety disorders than depressive disorders, although school refusal children with depression also complain of somatic symptoms (Last, 1991). Recurrent abdominal pain is the most frequent symptom and affects approximately 40% of separation anxious and 20% of depressed school refusal children (Apley & Naish, 1957; Levine & Rappaport, 1984; Livingston, Taylor, & Crawford, 1988). Children with somatic complaints are generally brought, in the first instance, to the attention of local and/or family doctors when their symptoms prevent them from attending school (Strauss, 1990). It is often difficult to make clear diagnoses because somatic complaints may mask the underlying problem of school refusal. Separation anxiety is generally the primary disorder, although it may have been preceded or antedated by disorders such as overanxious disorder and depression (Last, 1989; Last, Strauss, & Francis, 1987; O'Brien, 1982).

In summary, psychoanalytically oriented theorists stress the importance of early experiences in children's emotional development. Genetic and environmental factors also influence children's emotional development. Children can be born genetically predisposed towards having an emotional disorder and the way in which learning, specific stimuli, or stressful

situations interact with biological predispositions determines whether maladaptive behaviours do or do not occur, while difficulties within the mother/child relationship significantly affect children's future functioning and may precipitate separation anxiety.

Separation anxiety resulting from insecure mother/child relationships has been accepted as a major causal factor in school refusal. There is disagreement among researchers, however, about separation anxiety and school phobia as distinct disorders and the prevalence of depression in separation anxiety, school phobia, and/or school refusal.

When school refusal is considered to be due to separation anxiety the incidence of depression is around 30% with the mean age at onset being 9.4 years. When school refusal is considered to be due to school phobia the incidence of depression is around 25% with the mean age at onset being 14.3 years. When school refusal is seen as the interplay of school avoidance behaviour and separation anxiety, the incidence of depression is not assigned to a particular age group.

In the next chapter, literature pertaining to the identification and incidence of school refusal, outcomes of school refusal behaviour, and the classification and treatment of school refusal will be reviewed. The rationale for, and outline of, the study will be presented at the end of the chapter.

CHAPTER 3

IDENTIFICATION, CLASSIFICATION, & TREATMENT OF SCHOOL REFUSAL

The controversial aspects of school refusal which were discussed in Chapter 2 have also been considered in numerous articles detailing its identification, classification, and treatment. Although researchers generally agree that the identification and subsequent treatment of school refusal can be extremely traumatic for children and their families, they do not agree on methods of treatment or who should be involved in the process. There is also disagreement about attempts to classify children with school refusal either by symptoms manifested, or age at presentation. This chapter will present views about the identification, incidence, and classification of school refusal; the outcomes of school refusal behaviour both during and after the compulsory school years; differences between adolescent and preadolescent school refusers; the philosophy underlying each treatment method; and results of studies into the success, or failure, of different methods.

A great number of studies presented in the literature reviewed in this, and the previous chapters have involved large groups of children/ adolescents and have presented data about the incidence and classification of school refusal, characteristics of children/adolescents and their parents, the success and/or failure rate of various treatment methods, and the outcomes of school refusal behaviour (d'Amato, 1962; Kearney & Beasley, 1994; King & Gullone, 1990; Sperling, 1961). Case studies have mainly presented data about children's/ adolescent's developmental history, their school refusal history, treatment and outcome of their school refusal, and their current situation. Their characteristics and those of their parents (particularly mothers) plus the mothers' own school history have also been

presented (Buell, 1962; Hagopian & Slifer, 1993; Hawkes, 1981; Hersov, 1980; Smith & Sharpe, 1970; Szyrynski, 1976).

Identification of School Refusal

It is often difficult to identify potential school refusal children as their fear and anxiety about attending school is generally masked by physical symptoms. The symptoms may vary in intensity but usually increase following the weekend and school holidays. Once children are allowed to stay at home their symptoms disappear (Millar, 1961; O'Brien, 1982; Silber, 1982). Hence, it would seem to be important that these children are identified early and referred to appropriate agencies for treatment before prolonged school absences result (Scott et al., 1995).

Berg, Nichols, and Pritchard (1969) established four diagnostic criteria for the identification of school refusal:

* severe difficulty in attending school - often amounting to prolonged absence;
* severe emotional upset - shown by such symptoms as excessive fearfulness, undue tempers, misery, or complaints of feeling ill without obvious organic cause on being faced with the prospect of going to school;
* staying at home with the knowledge of the parents, when they should be at school, at some stage in the course of the disorder; and
* absence of significant anti-social disorders such as stealing, lying, wandering, destructiveness and sexual misbehaviour (p. 123).

Berry and Lizardi (1985) expanded the criteria mentioned immediately above and suggested that guidelines be organised into three behavioural categories:

* children's school behaviours including fearfulness, non-participation in group activities, anxiety about academic performance, and increased excused absences;
* personal behaviours including manifestations of anxiety, depression, and panic, frequent somatic complaints, and a tendency towards perfectionism and self-criticism; and
* family characteristics including maternal/child separation anxiety, traumatic home situations or changes in home environment, paternal overinvolvement in work, communication difficulties between parents, and maternal overprotection that fosters children's continued dependence.

Indicators within each category provide a frame of reference for medical and education workers.

The Berg et al. (1969) criteria appear to be more frequently cited and are considered to be more appropriate than the criteria proposed by Berry and Lizardi (1985) as they incorporate both psychodynamic and behavioural perspectives (Kearney et al., 1995; Ollendick & Mayer, 1984).

A number of researchers have suggested that the incidence of school refusal is increasing although there have been no studies to support this statement (Gordon & Young, 1976; Ollendick & Mayer, 1984; Paige, 1993). It may be that the growing recognition of school refusal has resulted in more cases being referred to appropriate professionals or agencies (Bonstedt, Worpell, & Lauriat, 1961; Cooper, 1966b; Heath, 1985).

Incidence of School Refusal

Want (1983) has suggested that the exact incidence of school refusal is unknown because many professionals have difficulty distinguishing between

truancy and school refusal. In the general population of school-age children, however, the incidence of school refusal is estimated at 1.7% (Baideme, Kern, & Taffel-Cohen, 1979; Doll, 1987; Smith, 1970; Smith & Sharpe, 1970). For children and adolescents referred to mental health/child guidance clinics with school refusal, the estimates are higher. Researchers generally cite figures of between 4% and 8% (Berg, 1992; Hersov, 1985b; King, Tonge, et al., 1998; Marks, 1987; Ollendick & Mayer, 1984; Weitzman et al., 1982).

Confusion about the incidence of school refusal arises when researchers fail to make the distinction between clinically referred children and the general population of school-age children. When this occurs statements can be unclear and misleading:

* 10% of children present with school refusal at some time during their school years (De Sousa & De Sousa, 1980);
* Between 5% and 8% of all school-aged children are school refusers (Kearney & Silverman, 1991, 1993, 1995); and
* Up to 20% of adolescents in the general school population experience school refusal problems (Ficula et al., 1983).

According to the estimates given immediately above this would mean that up to one in 10 children and up to one in 20 adolescents could present with school refusal. The estimates of up to 8% of clinically referred children and adolescents, and approximately 1.7% of the general population of school-age children would appear to be more accurate (King, Ollendick, et al., 1998) although Trueman (1984b) has suggested that the estimate of 1.7% in the general population of school-age children is too high as it would mean that approximately one out of every 59 children is a school refuser. Notwithstanding the disagreement over the incidence of school refusal,

researchers tend to agree that if left untreated, school refusal contributes to a variety of long-term psychological and/or emotional problems (Kearney et al., 1995).

Outcomes of school refusal behaviour

Children with school refusal have a poor prognosis. Their unwillingness, or refusal, to attend school has many side-effects (King, Ollendick, et al., 1998; King, Tonge, et al., 1998; Want, 1983). During their school years it may cause:

* an inability to form and maintain meaningful peer relationships;
* disruption to schooling, delayed learning, and/or academic deterioration;
* school or legal conflicts;
* a lack of independence and autonomy; and
* suicidal ideation and/or attempts and panic attacks (Heath, 1985; Paige, 1993; Strzelecki; 1984).

During their adult years it may result in:

* anxiety, depression, panic attacks, agoraphobia, and/or multiple phobias;
* alcoholism and antisocial behaviour; and
* marital and occupational difficulties, work and/or college avoidance (Flakierska-Praquin, Lindstrom, & Gillberg, 1997; Kearney, 1995; Kearney & Silverman, 1991; Murray, 1997; Waldron, 1976).

The negative outcomes of school refusal are obvious and researchers have agreed that a set of criteria for diagnostic purposes is necessary for the prompt identification and subsequent treatment of school refusal (Ollendick & Mayer, 1984). Paccione-Dyszlewski and Contessa-Kislus (1987)

have suggested that the most important factor in the selection and planning of treatment is the identification of an appropriate classification system.

Classification of School Refusal

Children with school refusal are not a homogeneous group. Although attempts have been made to identify and classify them according to personal and parental characteristics (in particular, maternal), and family composition and dynamics, little agreement has been reached (Chazan, 1962). Areas of disagreement include: children's socioeconomic status; birth order; intelligence; and personality (Table 3.1). Areas of agreement include: children's age; predominant gender; family size; and maternal and paternal characteristics (Table 3.2). Efforts have also been made to classify children into subtypes by proposing a theoretical link between their age and the extent of their pathology. Children younger than 11 years are perceived as being less disturbed, their symptoms more acute, and the onset of their school refusal more sudden. Children older than 11 years are seen as having more serious personal pathology, recurring symptoms, and onset is more gradual (Berg, 1970; Cooper, 1966a; Leton, 1962; Paige, 1993; Trueman, 1984b).

Characteristics of school refusal children and their parents. Early researchers considered that children with school refusal were above average in intelligence, and came from materially good homes where family relationships were emotionally tense (Blagg, 1987). Recent researchers have suggested that school refusal occurs in children at different levels of intelligence and from varied socioeconomic backgrounds. Families can be

lacking emotional stability, although they are generally united and cohesive (Kahn et al., 1981; Sherman & Formanek, 1985).

Table 3.1

Characteristics of School Refusers - Areas of Disagreement

Socioeconomic Background
More children from middle/upper-class families - parents place more value on education
No relationship to professional status or social class, although children come from materially good home backgrounds
Birth Order
No pattern but a tendency for lateness in birth order if more than 2-3 children in family
Significant numbers (80% to 90%) of only, oldest, or youngest children
High incidence of children second in birth order
Intelligence
Above average to high average - children have fewer social contacts, use intellectual abilities to achieve academic and parental gratification
No more or less intelligent than non-school refusers
All ability ranges affected (may be low academic achievers and deficient socially) but majority average to above in both areas
Personality
Boys submissive and sensitive - close physical mother/boy relationships
Girls aggressive and defiant
Both boys and girls - dominating, wilful, stubborn

Compiled from: Adams, McDonald, & Huey (1966); Berg, Butler, & McGuire (1972); Berg, Collins, McGuire, & O'Melia (1975); Chazan (1962); Cherry (1992); Cooper (1966b); Hampe, Miller, Barrett, & Noble (1973); Harris (1980); Lall & Lall (1979); Zelan (1991).

School refusal children appear to be timid and withdrawn away from the home setting and more sensitive, dependent, and introverted than the

average school population (Blagg, 1987; Cooper, 1986). Their school refusal behaviour is precipitated by traumatising events (i.e., family illness, divorce, death) and/or stressful school experiences (Jenni, 1997; King, Tonge, et al., 1998). Children of all ages can be affected, although the peak age of onset is when children change from primary to secondary school (Marks, 1987).

Table 3.2

Characteristics of Children and Parents - Areas of Agreement

School Refusal Children - Age, Gender, Family Size
5-7, 11-12, 13-14 years, major peak between 11-12 years
Incidence equally distributed across sexes, small to average size families
Mothers - Personality, Age, Anxiety, Relationship with own Mother
Domineering, overindulgent, overprotective, tendency to be older
Increases risk of children's separation anxiety/school refusal
Often experienced poor relationships, deprived of maternal love as child, neurotically involved with mother, ability to give emotional support dependent on how treated as child
Fathers - Personality, Family Involvement, Relationship with own Mother
Quiet, passive, withdrawn from family interaction - often absent due to work commitments
Give little support and leave responsibility of child rearing to wives yet criticise their efforts
Have/have had, dominating rejecting mothers - maternal ties not resolved

Compiled from: Jenni (1997); King, Ollendick, et al., 1998; McKnew, Cytryn, Effron, Gersham, & Bunney (1979); Nursten (1958); Sherman & Formanek (1985); Smith (1970); Takagi (1972); Weissman et al. (1987); Wolff & Acton (1968).

Certain parental characteristics, such as maternal (or occasionally paternal) unresolved dependency on their own mothers, hostility towards

their own mothers, feelings of maternal inadequacy, and maternal anxiety and depression are thought to predispose children to school refusal (Futterman & Hoffman, 1970; Gittelman, 1986; Kahn et al., 1981). Qualities in family interaction, such as mutual clinging of mothers and children, maternal overindulgence and overprotection, inconsistencies in discipline, or marital disharmony are also contributing factors (Huffington & Sevitt, 1989; Pritchard & Ward, 1974; Waldron, Shrier, Stone, & Tobin, 1975).

Mothers often consider children with school refusal to be more important to them than their husbands (Hansen et al., 1998). Children are aware of this and feel the burden of the role they play in family dynamics. The resulting family imbalance creates difficulties in the areas of role performance and control (Bernstein & Garfinkel, 1988; Bernstein, Svingen, & Garfinkel, 1990; Huffington & Sevitt, 1989; Johnson, 1979; Pritchard & Ward, 1974).

Parents of school refusal children participate less in outside social activities and spend more time with their families than with friends. They often live in close proximity to family members, particularly maternal parents (Talbot, 1957). Mothers are more likely to stay at home and assume a more prominent role in family affairs than go out to work. They discourage autonomy in their children while encouraging excessive dependence, affection, and communication. Their children show similar characteristics early in life, particularly characteristics of anxiety and depression (Berg, Butler, Fairbairn, & McGuire, 1981; Berg & McGuire, 1974; Coolidge & Brodie, 1974; Turner, Beidel, & Costello, 1987).

Subtypes of school refusal. A number of researchers have attempted to classify school refusal children according to subtypes. Coolidge et al.

(1957) proposed two subtypes - neurotic and characterological - which became precursors to various other classification systems. Kennedy (1965) described a Type I acute, and a Type II chronic school refusal (Table 3.3).

Table 3.3

Subtypes of School Refusal

Type I - Acute	Type II - Chronic
Present illness first episode	Second, third, fourth episode
Monday onset following illness previous Thursday/Friday	Monday onset following minor illness not a prevalent antecedent
Acute onset	Incipient onset
Lower grades most prevalent	Upper grades most prevalent
Concern expressed about death	Death theme not present
Mother's health in question - is sick or child thinks so	Health of mother not an issue
Good communication between parents	Poor communication between parents
Parents well adjusted in most areas	Mother neurotic, father has character disorder
Father competes with mother in household management	Father has little interest in household or children
Parents understand dynamics of school refusal	Parents very difficult to work with

Kennedy (1965).

The 10 descriptive criteria listed by Kennedy immediately above are still cited extensively in the literature. Other classification systems have been proposed and although from 2-to-5 subtypes of school refusal have been defined, and differences exist between each classification system, apparent similarities in each subtype to Type I or Type II school refusal have been noted (Table 3.4) (Paccione-Dyszlewski & Contessa-Kislus, 1987).

Table 3.4

Similar Subtypes of School Refusal to Kennedy's Type I and Type 2

Type I - Acute	Type II - Chronic
Acute - Berg et al.	Chronic - Berg et al.
Common - Sperling	Induced - Sperling
Mild acute - Marine	Severe chronic - Marine
Proactive - Taylor and Adelman	Reactive - Taylor and Adelman
Type I and II - Atkinson et al.	Type III - Atkinson et al.

Compiled from: Atkinson, Quarrington, Cyr, & Atkinson (1987, 1989); Baker & Wills (1978); Marine (1973); Paccione-Dyszlewski & Contessa-Kislus (1987); Paige (1993); Sperling (1967); Taylor & Adelman (1990).

Regardless of the classification system and the number of subtypes within the system, subtypes of school refusal share a commonality of symptoms which include:

* morbid fear of going to school;
* frequent somatic complaints, such as head and stomach aches;
* existence of symbiotic mother/child relationships and fear of separation;
* generalised anxiety about darkness, noises, and crowds;
* irrational fear of impending disaster; and
* home/school conflict, and continuous school absences as opposed to intermittent school absences (Kennedy, 1965; Klungess & Gredler, 1984; Marine, 1973; Strzelecki, 1984).

In conclusion, it would appear that it is more difficult to classify children with school refusal according to their personal characteristics than it is to classify their parents. Children have been reported as coming from either middle to upper-class families, or from all levels of society. They

occupy no specific birth order positions, or extreme birth order positions. They are no more or less intelligent than children without school refusal, or average to well above in intelligence. They can be either highly dependent and anxious, or wilful and controlling.

The major peak of school refusal has been reported as occurring between ages 11 and 12 years with minor peaks between ages 5 and 7 and 13 and 14 years. Girls and boys are equally affected; their school refusal behaviour is generally precipitated by change to a new school or other events that threaten their security and that of their mothers. Families are small to average in size and generally remain intact but their interaction is dominated by the children who present with school refusal.

School refusal must be identified early so that prompt treatment can be initiated. The appropriate treatment can be selected according to the subtype of school refusal that children fit. The most widely accepted system, and the one that has been assimilated into more recent classification systems, is Kennedy's acute and chronic school refusal.

The subtype of school refusal appears to determine the treatment method used. A short-term, highly focused treatment is considered to be more successful with acute school refusers while long-term, intensive treatment is considered to be more successful with chronic school refusers. There are conflicting views among researchers, however, about whether different treatment methods should be used with different age groups of children, the success rate of certain treatments, and the speed with which children should be returned to school.

Treatment of School Refusal

Researchers recognised as early as 1945 that a distinct relationship exists between prompt therapeutic intervention and the alleviation of school refusal behaviour (Klein, 1945; Lassers et al., 1973; Reger, 1962; Waldfogel, Tessman & Hahn, 1959). The longer the return to school is delayed, the more entrenched the school refusal becomes. As a consequence, children's behaviour regresses thereby extending, or intensifying their anxiety and fear of school. They fall behind with school work and become embarrassed at the prospect of facing teachers and peers. They gain extra attention at home, their fears of school are accepted as real, and their behaviour reinforces the neurotic family patterns which led to the development of their school refusal initially (Bonstedt et al., 1961; Eisenberg, 1959; King & Ollendick, 1989b; Leventhal et al., 1967; Yule et al., 1980).

A number of researchers, however, have advocated a gradual return to school and have suggested that a gradual approach relieves all pressure on children. Since pressure to return to school only exacerbates children's anxiety a gradual approach assures greater success, both with treatment and later social and work adjustment (Greenbaum, 1964; Valles & Oddy, 1984; Warnecke, 1964; Yule, 1979).

When school refusal is mild and uncomplicated it can generally be managed with supportive measures only - school friends, relatives, or family friends can accompany children to school rather than mothers (Berryman, 1959; Framrose, 1978; Lewis, 1980). When school refusal is more pervasive it requires treatment by professionals (guidance officers, social workers, psychologists, psychiatrists). Their philosophical views will dictate the type of treatment or psychotherapy that is used (Brulle et al., 1985).

Psychotherapy encompasses a wide range of theoretical models and therapeutic techniques, with each psychotherapy resembling the other in that it aims to incur changes in children's behaviour by helping them to think, feel, and act differently (Corsini, 1984; Lynn & Garske, 1985; Tuma, 1989). The main psychotherapies used in the treatment of school refusal are psychoanalytic/psychodynamic therapy, family therapy, behaviour therapy, pharmacotherapy, hospitalisation, and home tuition (Blagg, 1987; Blagg & Yule, 1984; Gullone & King, 1991; Lewis, 1980).

Current Psychotherapies

The theories proposed by Freud and Adler (Chapter 2) have influenced psychotherapy since the early 1900s. Although their psychoanalytic approach has been developed and modified over the years, most forms of modern-day psychotherapy include some elements of psychoanalytic theory or technique (Arlow, 1984; Baker, 1985).

During the 1940s and 1950s, school refusal was almost exclusively conceptualised within a psychoanalytical framework (Brown, Copeland, & Hall, 1974; Trueman, 1984a) and treatment for both mothers and children was intensive and individual (Jacobsen, 1948; Weinberger et al., 1973; Yule, 1979). Prevailing psychoanalytic/psychodynamic models still focus on individual therapy - the process tends to be lengthy and aims at uncovering repressed fears centring on the mother/child relationship; reducing anxiety; improving self-esteem; and alleviating symptoms (Brown et al., 1974; Garvey & Hegrenes, 1966; Hersen, 1971; Lewis, 1986).

Psychoanalytic/psychodynamic therapy. In the initial stages of psychoanalytic/psychodynamic therapy, a therapeutic alliance is fostered

between children and therapists. Opportunities are provided for children to express their feelings verbally and through play. Attention is drawn to the content of their actions and verbalisations (Tuma, 1989). Children are able to communicate to therapists their feelings of anger, fear, and resentment about separation from, and dependency on, mothers. These feelings are then transferred onto therapists who children perceive as imposing difficult demands on them (Waldfogel et al., 1959). This process increases children's self-knowledge, gives them insight into their feelings, and behaviour, and improves their self-mastery of separation anxiety/school refusal (Contessa & Paccione-Dyszlewski, 1981; Harris, 1980; Lewis, 1986).

High rates of successful school return have been reported, for example, 71% (Rodriguez et al., 1959), 86.9% (Warnecke, 1964), and 94.7% (Glaser, 1959). Other researchers have indicated equally high success rates with large groups of children (Baker & Wills, 1979; Coolidge, Brodie, & Feeney, 1964). Success with single cases has been reported by Framrose (1978), Leventhal et al. (1967), and Olsen and Coleman (1967).

In contrast to psychoanalytically oriented therapy, family therapists see school refusal as resulting from the family's inability to accept change and to widen its boundaries.

Family therapy. Family therapists propose a shift of focus from individual identified children to the family as a whole (Bryce & Baird, 1986; Pfeiffer & Tittler, 1983). Children are not seen in isolation but within the family context, as the most common psychopathological interactions generally involve all family members. The family is seen as a system in which the behaviour and experience of one family member is understood in relation to the behaviour and experience of all other family members (Cerio, 1997;

Foley, 1984; Foster & Gurman, 1985; Pfeiffer & Tittler, 1983). Symptomatic behaviours exhibited by school refusal children are the result of dysfunctional family interaction and each family member is seen as being instrumental in encouraging and maintaining the school refusal behaviour for fear that changes could incur worse consequences (Baideme et al., 1979; Burgess & Hinkle, 1993; Hawkes, 1981; Lewis, 1980; Messer, 1964).

High success rates in returning one or two children to school have been reported (Baideme et al., 1979; Burgess & Hinkle, 1993; Conoley, 1987; Hawkes, 1982; Hsia, 1984). Success with groups of children has been reported as 80% (Skynner, 1974) and 100% (Bryce & Baird, 1986).

Behaviour therapy. Behaviour therapy was developed during the late 1950s by Eysenck, Skinner, and Wolpe as an alternative approach to psychoanalytically oriented therapies. Although it has expanded over the years and undergone significant changes, behaviour therapy has retained the basic concepts proposed by its originators (O'Leary & Wilson, 1975; Rimm & Cunningham, 1985; Wilson, 1984).

Behaviour therapists concentrate on the present. They spend time gathering information about children's pasts but only for the purpose of expediting treatment (Foley, 1984; Rimm & Cunningham, 1985). They regard school refusal as a learned behaviour that is rewarded, and thereby reinforced, either consciously or unconsciously. Their approach to school refusal is a problem-solving one and their major goal is to effect an early return to school (Cooper, 1973; Hersen, 1971; Yule et al., 1980).

Behaviour therapy is directed towards eliminating circumstances that perpetuate children's maladaptive behaviours (Garvey & Hegrenes, 1966; Montenegro, 1968; O'Leary & Wilson, 1975; Wilson, 1984). An overall

behavioural treatment approach incorporates principles from both classical and operant conditioning (Blagg, 1981; Yule, 1979). Consistently high success rates in achieving school return with one child have been reported (Chapel, 1967; Esveldt-Dawson, Wisner, Unis, Matson, & Kazdin, 1982; Lazarus, Davison, & Polefka, 1965; Tahmisian & McReynolds, 1971). Studies involving groups of children have reported success rates of approximately 95% (Blagg & Yule, 1984) and 100% (Kennedy, 1965). When behaviour therapy and other treatment methods are unsuccessful, medication may be used to relieve children's excessive anxiety (Gittelman-Klein & Klein, 1980; Nice, 1968).

Pharmacotherapy. A frequently used medication in the treatment of school refusal is the antidepressant, imipramine (Allen, Leonard, & Swedo, 1996). Because imipramine was observed to block the spontaneous panic attacks of agoraphobic adults (a significant number of whom had suffered from childhood separation anxiety/school refusal), researchers assumed that it would be effective in reducing anxiety in school refusal children (Deltito, Perugi, Maremmani, Mignani, & Cassano, 1986; Gittelman-Klein & Klein, 1973; Gittelman-Klein, Klein, & Oaks, 1971; Tyrer, 1986). Results from the majority of studies indicate that children's anxiety declines during treatment and school attendance improves, however, the methodology of some studies, and the efficacy of other antidepressants trialled, has been questioned (Gittelman & Koplewicz, 1986; Klein, Koplewicz, & Kanner, 1992).

Chlordiazepoxide (d'Amato, 1962), sodium pentothal (Nice, 1968), and imipramine (Rabiner & Klein, 1969) have been administered in open clinical trials to school refusal children. The success rate for improved school attendance was high but results were questionable as none of the studies

were placebo-controlled. Researchers have suggested that double-blind, placebo-controlled studies are the most reliable method of testing the efficacy of antidepressants (Gittelman & Koplewicz, 1986).

Hospitalisation. School refusal that is severe, and resistant to treatment by professionals in the community, often requires the intensity, and concentration, of treatment administered in a hospital setting (Borchardt, Giesler, Bernstein, & Crosby, 1994; Hersov, 1980; King, Ollendick, et al., 1998; Radin, 1968). Although hospitalisation (with psychotherapy) can be expensive in terms of both length of hospital stay and professional input, results of studies indicate successful school return in 50% to 59% of cases (Berg, 1970; Berg, Butler, & Hall, 1976; Berg & Fielding, 1978; Hersov, 1960b; Weiss & Burke, 1970).

Researchers who examined the social adjustment of former hospitalised adolescent school refusers, however, found that approximately 30% had problems with social isolation and peer interactions. They coped poorly with family and community situations and had either neurotic symptoms or severe emotional disturbance (Berg, 1970; Berg & Fielding, 1978; Berg et al., 1976; Borchardt et al., 1994).

Home tuition. An alternate treatment to other methods reviewed is home tuition (with or without psychotherapy). Home tuition allows school refusers to stay at home for weeks, or even months, at a time. Mothers may desire home tuition for their children as a way to keep them tied to them at home in dependent relationships. This appears to be detrimental for children both socially and academically, reinforces their desire to stay at home, and denies them the opportunity to recover (Berg, 1985; King, Tonge, et al.,

1998; Marine, 1968; Millar, 1961; Popper, 1993).

The majority of researchers have suggested that home tuition appears to reinforce children's pathology and encourage secondary gains. By accepting children's apparent inability to return to school as a real inability, the family reinforces their regression (Cooper, 1966a; Lewis, 1980). Once children are able to continue their academic progress at home their motivation for change is considerably diminished. The home situation becomes more comfortable and there is less pressure on the family to alter in any way (Eisenberg, 1959; Weiss & Cain, 1964).

Advocates of home tuition have reported success with school return and progression to higher education (Knox, 1989a, 1989b). Researchers opposed to home tuition have indicated that home tuition may actually inhibit school return. Compared to other treatment methods it is the least successful in effecting school return (Blagg & Yule, 1984).

Comparison of methods. Behaviour therapy has been reported as the most successful treatment approach in school refusal (Ayllon, Smith, & Rogers, 1970; Gullone & King, 1991). In comparison to the other methods reviewed behaviour therapy:

* is cost effective;
* does not intrude into children's home and school life:
* is effective in returning children to school quickly and keeping them there; and
* produces a rapid alleviation of symptoms, especially in preadolescent school refusers (Blagg & Yule, 1984; Kolko, Ayllon, & Torrence, 1987; Prout & Harvey, 1978; Thyer & Sowers-Hoag, 1986). Adolescent school refusers neither appear to respond more to one

treatment than another, nor are they as successful in returning to school as preadolescent school refusers (Croghan, 1981). They are less responsive to treatment and so often require different management techniques to preadolescents who respond positively to concentrated treatment and prompt school return (Berg, 1980b; Berg & Jackson, 1985; Chotiner & Forrest, 1974; Coolidge et al., 1960).

School Refusers as Adults

Compared to adolescent school refusers, preadolescent school refusers have a generally good prognosis for later life (Tietz, 1970). Preadolescents reviewed in one of the longest follow-up studies reported (15-20 years) were found to be socially well-adjusted, with an absence of severe psychiatric problems. Adolescents reviewed in the same study were found to have a limited sphere of social relationships, and a higher risk of adult psychiatric disorders (Flakierska, Lindstrom, & Gilberg, 1988).

Successes reported above by Flakierska et al. (1988) have been replicated by other researchers in similar long-term follow-up studies. Although these studies were mainly conducted in the 1960s, results appear to confirm that preadolescent school refusers function well after the compulsory school years while adolescent school refusers have difficulties with interpersonal relationships, and are emotionally dependent. Adolescent school refusers are also more likely to have a tendency towards agoraphobia (de Aldaz, Feldman, Vivas, & Gelfand, 1987; Hersov, 1980; Hodgman & Braiman, 1965; Nursten, 1962; Weiss & Burke, 1970; "When Truants," 1982).

Adolescent male school refusers, as adults, either remain at home with mothers, or marry women with strong maternal strivings. Both types of

women are overcontrolling, foster dependent relationships with sons/husbands, and subconsciously encourage them to stay home (Pittman, Langsley, & DeYoung, 1968). Adolescent female school refusers, as adults, frequently shift their dependency from mothers to husbands and tend to live either in the family home after marriage, or in close proximity to it (Coolidge et al., 1964).

It is difficult to present a definitive account of adolescent school refusers in further education or work situations due to a lack of studies in the area. The few studies undertaken, however, have indicated that adolescent school refusers have had less difficulty pursuing further education or going to work than they have had going to school (Baker & Wills, 1979; Berg et al., 1976; Valles & Oddy, 1984).

In summary, the majority of psychotherapists consider that children who return to school promptly benefit, while those who receive home schooling stand to gain too many reinforcements making school return increasingly difficult. Positive results in effecting school return, however, have been reported by advocates of home schooling.

Notwithstanding the comparatively few studies conducted, and the lack of recent studies, behaviour therapy appears to be the most successful in terms of time, cost, and effectiveness. It is difficult to ascertain the true value of hospitalisation as all studies except one involved adolescents, and researchers have consistently reported that adolescents do not respond positively to treatment. Behavioural and family therapy studies have involved both preadolescent and adolescent school refusers which may account for their higher success rates.

Preadolescent school refusers respond positively to treatment irrespective of the treatment approach. They continue to function well with

increasing age, are more socially competent in later life, and seldom display severe neurotic symptoms. Adolescent school refusers, on the other hand, have problems with relationships, tend to be poorly-adjusted socially, and prone to psychiatric illnesses although they function reasonably well in further education and work situations.

Rationale for, and Outline of, the Project

School refusal has been explained in terms of separation anxiety and/or school phobia with separation anxiety being suggested as the more common causal factor (2.5 times more prevalent than school phobia), especially among younger children. The development of anxiety and phobic disorders of childhood can be attributed to interrelated biological and psychosocial variables. Mother/child attachment (secure or insecure), parental psychopathology (particularly maternal), and family dynamics affect children's personality development with the quality of early mother/child interaction being influenced by children's socialisation within the family, sibling rivalry, and the child's temperamental style.

Researchers have suggested that temperamental style, in particular, influences the quality of early parenting, mother/child relationships, and maternal mood. It has been reported that, as infants, easy children are contented, positive, and have regular sleeping and eating patterns. They approach unfamiliar people, are outgoing, and adapt to changes in their environment. Children who are difficult as infants, however, have temperamental tendencies towards irritability, negativity, difficulty in feeding, and irregularity of sleep patterns. They are shy and fearful as toddlers, hesitant in adapting to new situations or people, and prone to developing anxiety, low self-esteem, and avoidant behaviour. Their

temperamental style may predispose them first to behavioural inhibition then separation anxiety, followed by panic disorder with agoraphobia.

Children's temperamental style has also been reported as a significant factor in predicting difficulties with school adjustment in the early years. Behaviourally inhibited children have been reported as being quiet, anxious, and withdrawn in kindergarten/preschool and during the first few years of school. They have also been reported to be cautious, introverted, and non-interactive on the first day of kindergarten/preschool, and on follow-up over the years to the age of 7 years 6 months.

Although a number of researchers have suggested that behavioural inhibition leads to separation anxiety (and/or avoidant and overanxious disorder) followed by panic disorder with agoraphobia, only three research teams have suggested that behavioural inhibition may be linked to separation anxiety and school refusal followed by panic disorder with agoraphobia (i.e., Deltito & Hahn, 1993; Rosenbaum et al., 1988, 1989). None of these teams, however, specifically discussed behavioural inhibition in relation to separation anxiety and school refusal, rather, the emphasis has been on behavioural inhibition as a precursor to separation anxiety and future anxiety disorders. King, Ollendick, et al. (1998) have noted that behaviourally inhibited children seen in their clinics appear to be at risk for developing school refusal. Again, behavioural inhibition was not specifically discussed in relation to separation anxiety and school refusal.

Given that 75% to 80% of children with separation anxiety suffer from school refusal it is surprising that there have been few, if any, studies that have specifically examined behavioural inhibition as a precursor to separation anxiety and school refusal. It is also surprising that so few studies have been undertaken to address the problem of school refusal in

children between ages 5 and 7 years when school refusal has frequently been reported as being prevalent in this age group. In Australia, where some children do not begin school (after attending preschool) until they are 6 years old, it is conceivable that they could manifest symptoms of separation anxiety/school refusal in the preschool setting.

As the literature has indicated, children's temperamental style is a potential risk factor (particularly for behaviourally inhibited children) in the development of separation anxiety. If behavioural inhibition can be identified much earlier than anxiety disorders, as some writers have suggested, it may be possible to identify children at-risk for separation anxiety/school refusal while they are still at preschool.

Major studies in the United States have followed behaviourally inhibited children from the age of 21 months through to 12 years. Investigators have reported that behavioural inhibition remains stable in the majority of children. It affects their ability to establish peer relations, develop independent behaviours, and adjust to new people and situations in the home and, in particular, the kindergarten/preschool/school settings.

Perhaps the most notable examination of behavioural inhibition was conducted at the Harvard Infant Study Laboratory in 1984 by Garcia Coll. The purpose of the Harvard Study was to evaluate systematically the relationship between:

* laboratory observations of children's individual differences in behavioural inhibition to unfamiliar people/situations;
* the heart rate and respiratory reactions of children to unfamiliar information; and
* mother's reports of children's reactions to unfamiliar people/ situations.

It was expected that those children who were identified as consistently inhibited in unfamiliar laboratory situations would display higher heart rates to unfamiliar information than would children identified as consistently uninhibited.

Subjects for the Harvard Study were recruited by letter or telephone. Parents willing to participate in the study were required to answer (by telephone interview) eight questions based on the Toddler Temperament Scale (TTS) (Fullard, Mc Devitt, & Carey, 1978), pertaining to their child's approach/withdrawal responses. From these prescreen interviews, the 117 male and female infants identified participated in behavioural and psychophysiological laboratory assessments at 21-22 months of age and again at 31-32 months of age. Behavioural assessments at 21-22 months consisted of six sessions: the first three involved the experimenter, mother, and infant; the fourth involved an unfamiliar woman; the fifth involved an unfamiliar object, and the sixth involved mother/infant separation. Children were classified as inhibited if they exhibited nine or more inhibited behaviours during each of the six sessions; uninhibited if they exhibited two or fewer inhibited behaviours; or neither inhibited or uninhibited if they exhibited three to eight inhibited behaviours. Psychophysiological assessments consisted of four visual and two auditory presentations during which the child's heart rate and respiration were recorded.

In the next phase of the study, both parents were required to complete (at home) the TTS which asks questions appropriate to the nine temperamental characteristics that children may exhibit: activity level; rhythmicity; adaptability; approach-withdrawal; threshold level; intensity of reaction; quality of mood; distractibility, and persistence and attention span. A second identical laboratory session involving 58 of the original 117

children was conducted 3-5 weeks after the initial session. Mothers were asked at the end of the session if their child's behaviour in laboratory settings was representative of their behaviour in normal situations.

Of the 58 children (31 were females), 28 were classified as inhibited and 30 as uninhibited. At 31-32 months of age, 20 inhibited and 20 uninhibited children were observed in the home during mother/child interaction. Approximately two weeks later, inhibited children were matched with uninhibited children and observed in peer play in a laboratory setting. Psychophysiological assessment followed the peer play session.

Results from Garcia Coll's (1984) study indicated that the tendency to be either consistently inhibited or uninhibited remained stable across a year, extremely inhibited children displayed significantly higher heart rates when presented with visual and auditory stimuli, and parental reports of children's behavioural inhibition/uninhibition correlated moderately with the laboratory observations. A number of subsequent studies were conducted over the following 10-11 years using the identified children. Some of these studies also included control children whose behaviour fell between the two extremes; children whose parent/s were being treated as outpatients for panic disorder and agoraphobia; and children with relatives without a psychiatric disorder. Although children were observed in kindergarten/ preschool and school settings, in the main, assessments were conducted in laboratory settings.

Researchers involved in the Harvard studies reported that 10-15% of American Caucasian children were either behaviourally inhibited or uninhibited in laboratory situations of uncertainty - in kindergarten/ preschool and school settings behaviourally inhibited children remained:

* quiet and socially avoidant with unfamiliar children and adults;

* reluctant to play with unfamiliar objects and initiate new activities;
* hesitant during peer play to make eye contact, approach, or speak to others;
* inclined to stay in close proximity to mothers and familiar adults (i.e., teachers);
* cautious in situations involving mild risk; and
* at risk for developing childhood anxiety disorders and multiple anxiety, overanxious, and phobic disorders in adulthood.

Other studies (i.e., Asendorpf, 1994; Kagan & Snidman, 1991b; Reznick et al., 1989; Rickman & Davidson, 1994; Schmidt et al., 1997) have been based on the Harvard Infant Study Laboratory method with assessment conducted within laboratory settings in sessions similar to those described previously (i.e., interaction with an unfamiliar female). Results replicated those mentioned immediately above.

The present study has been based on research undertaken at the Harvard Infant Study Laboratory, however, there are significant differences between the present and the Harvard Study in the way in which participants were identified and how data were collected.

In Study 1 of the present project, information was sought from mothers of 211 Year 1 children about their children's behaviour as a baby, a toddler, and when the child was 5-to-6 years of age. The aims of Study 1 were to:

1. describe mother's perceptions of children over the three periods;
2. describe the basis upon which mothers made their judgements;
3. examine the consistency of mother's judgements over the three periods; and

4. examine the incidence of behaviourally inhibited and uninhibited children within the sample.

In Study 2, behaviourally inhibited preschool children (Group 1) at-risk for separation anxiety/school refusal were identified during their last term of preschool by preschool/kindergarten staff. Group 1 was then compared to a similar group of behaviourally uninhibited peers (Group 2). The individual reactions of all Group 1 and Group 2 children to the transition from preschool to Year 1 (primary school) were rated by teachers at three periods through to the end of Semester 1, Year 1. Teachers also assessed children's social behaviours through to the end of Semester 1.

Questions addressed in Study 2 were:

1. Was the behavioural inhibition exhibited by Group 1 children at preschool apparent at a much younger age, and would mothers rate these children as having been difficult as infants and shy, timid, and cautious with strangers as toddlers?
2. Did Group 1 children have difficulty separating from mothers and settling into school, were they hesitant to initiate interaction with peers, and withdrawn with unfamiliar adults and peers?

In Study 3, information was sought from both mothers and present teachers of former school refusal children/adolescents. Interviews were conducted with mothers to determine whether these children/adolescents had been temperamentally difficult as infants, behaviourally inhibited in preschool, and showed signs of separation anxiety either at preschool, or in the early school years.

Questions addressed in Study 3 were:

1. Did former school refusal children/adolescents manifest behavioural inhibition before they manifested separation anxiety?

2. As behavioural inhibition is a relatively enduring trait, were these children/adolescents still anxious, cautious, and introverted in the school situation?

3. Were mothers of former school refusal children/adolescents behaviourally inhibited and anxious as children, did they have problems with school adjustment and were they enmeshed with their own mothers - as children and at present?

Information gathered in Study 3 will be presented in case study form. Case studies have the advantage of being more detailed and descriptive (especially when there are small numbers of participants) than the quantitative method of research used in Studies 1 and 2. It is also possible to present data subjectively, and to discuss and compare participant's individual differences. The following chapter will discuss the development of the instruments.

CHAPTER 4

PARENTAL PERCEPTIONS OF CHILDREN'S BEHAVIOUR

Study 1 involved the development and administration of two questionnaires to be used in this and the following studies to identify children and collect mothers' perceptions of children from birth to 5-to-6 years and teachers' perceptions of children at preschool and/or primary school. In this study, specific details about children (i.e., birth order, family make-up) were not required as the data served only to set a baseline of behaviours against which children in Studies 2 and 3 might be compared.

Method

Participants

Mothers of 211 Year 1 children participated in Study 1. The children attended one of 12 Brisbane state primary schools chosen because of their size, diversity of location, and socioeconomic setting. One school was in an inner Brisbane suburb (i.e., within five kilometres of the city centre) and was the smallest school with 18 teachers and 305 children. Four schools were within a 10-to-15 kilometre radius of the city centre and had 24-to-37 teachers and enrolments of 477-to-733 children. Seven schools were in outer Brisbane suburbs, (16-to-25 kilometres from the city centre) and had between 437-to-829 children and 21-to-44 teachers. The 102 boys and 109 girls in Study 1 were aged between 5 years 3 months and 5 years 11 months at the time the questionnaire was administered in March, 1997.

The Instruments

Questionnaire A. This questionnaire focused on the characteristics of inhibited children as reported in the Harvard Study. Items in this and the Harvard Study were based on the Toddler Temperament Scale (TTS) (Fullard et al., 1978).

The questionnaire was distributed to psychiatrists and therapists working within the Child and Youth Mental Health Service, (CYMHS) at the Royal Children's Hospital, Brisbane. They were asked to comment on, and/or suggest amendments to, the questionnaire about: issues which may not have been adequately addressed; inappropriate and/or awkward wording; and lack of clarity or purpose for items listed. The few changes that were suggested were mainly related to clarity of wording and format. Commensurate amendments were incorporated into the final version of the questionnaire.

Preschool teachers in three inner city preschools were asked to identify children in the last term of preschool who had exhibited at least four out of the six general characteristics reflecting inhibited behaviour (i.e., shyness, timidity) for prolonged periods. These children were then matched as closely as possible with children of a similar age, gender, place in the family, and parental status. All children were then rated by the preschool teacher on 12 items on a 1-to-5 scale (rarely, sometimes, usually, frequently, always). After two weeks, the teachers rated the children again. As their ratings did not change on retesting, no further changes were made to the questionnaire. The final version is given in Appendix A.

Questionnaire B. Items from Questionnaire A were incorporated into Questionnaire B which was also based largely on the Toddler Temperament

Scale. It asked questions about the nine characteristics that children may exhibit:

* activity level (e.g., was the child restful or fitful during sleep?);
* regularity or rhythmicity (e.g., did the child feed at variable times?);
* response to new situations or approach-withdrawal (e.g., how did the child react to unfamiliar people?);
* adaptability to change in routine (e.g., did the child warm quickly to new foods?);
* persistence and attention span (e.g., how long did the child stay with activities?);
* positive or negative mood (e.g., was the child contented and happy or just the opposite?);
* intensity of response or reaction (e.g., did the child react quietly or loudly to pleasure or displeasure?);
* level of sensory threshold (e.g., was the child sensitive to heat, cold, foods, or textures of clothing?); and
* distractability (e.g., did the child stop his/her activity when people entered the room?) (Willis & Walker, 1989).

Unlike the TTS, however, which seeks information about each of the nine characteristics during a 4-to-6 week period, Questionnaire B (Appendix B) sought information about each of the nine characteristics during two periods (as babies and toddlers) and about six characteristics when the children were 5-to-6 years of age.

Section 1 of Questionnaire B (as babies) consisted of 13 items that related to the characteristics listed immediately above. Four items were not included in Section 2 (as toddlers). Three items were not included because

they were not expressly applicable to that time period: regularity of mealtimes; distractability when eating; and reaction to loud noises (generally by the time children have reached toddlerhood, regular mealtimes have been established, they eat with the family, and are used to household noises). The fourth item (reaction to new situations) was similar to other items and incorporated into and renamed in Section 2. Of the nine items in Section 2, three (i.e., mood when awake, activity level when asleep, reaction to strangers) were deleted from Section 3 (5-to-6 years) as they did not expressly apply to that time period. Mood when awake related to the attention children needed from mothers during the day; activity level when asleep related to daytime sleeps (neither of these items are applicable to 5-to-6 year old children who attend school); and reaction to strangers was similar to other items and incorporated into and renamed in Section 3.

Mothers were asked to evaluate their child's behaviour by choosing one of three possible ratings for each item on the questionnaire. The first and third ratings described more extreme behaviours (i.e., showed no concern, a little concern, distress).

Procedure

Questionnaire A was distributed to psychiatrists and therapists in August, 1996, and to three preschools for test-retest reliability in late September, 1996. Questionnaire B was sent to 12 principals of Brisbane state primary schools in February, 1997. Letters explaining the purpose of the study, copies of Ethical Clearance for the study from Education Queensland, and stamped self-addressed envelopes were included with the questionnaire. Four hundred questionnaires were distributed to Year 1 teachers who distributed them to mothers of all children in their class. Two hundred and

eleven were returned. The approximate 50% response rate was reported by teachers to be mainly due to the difficulty of getting mothers with whom they had no face-to-face contact to return the questionnaire. Mothers who bought their children to school were able to question teachers about the study and its purpose and were more willing than others to participate. There were no issues about confidentiality as the names of children, mothers, teachers, and schools were not requested.

Results and Discussion

Mothers' Perceptions

Mothers were asked to evaluate their child's behaviour by choosing one of three possible ratings for each item on the questionnaire. The means and standard deviations of mothers' perceptions of their child's behaviour are presented in Table 4.1.

Table 4.1

Factors Associated with Children's Temperament across Three Periods

Factor	As Baby M	As Baby SD	As Toddler M	As Toddler SD	Age 5-6 M	Age 5-6 SD	P
Health status	1.3	.48	1.3	.48	1.2	.40	.02
Mood when awake	1.3	.51	1.3	.52			.39
Activity level when asleep	1.3	.53	1.4	.68			.01
Regularity of sleep times	1.6	.70	1.5	.83	1.3	.63	.00*
Regularity of meal times	1.4	.56					
Level of appetite	1.5	.60	1.5	.61	1.5	.60	.13
Distractability when eating	1.8	.62					
Reaction to family/familiar people	1.2	.44	1.2	.38	1.1	.34	.00*
Reaction to strangers	1.9	.58	1.8	.58			.33
Reaction to unfamiliar settings	1.5	.58	1.9	.65	1.6	.51	.00*
Reaction to loud noises	1.6	.59					
Reaction to new situations	1.8	.79					
Reaction to grandparents/babysitters	1.6	.63	1.2	.46	1.1	.25	.00*

NB: Ratings were 1 = positive; 2 = neutral; 3 = negative
* P < .006

Analyses of variance with repeated measures were undertaken for each of the items associated with children's temperament (e.g., health status, level of appetite) and the levels of significance are shown in Table 4.1. The Bonferroni adjustment was made to the level of significance producing a critical probability level of .006. As can be seen in Table 4.1 there are four items which reached the level of statistical significance (i.e., regularity of sleep times, reaction to family/familiar people, reaction to unfamiliar settings, reaction to grandparents/babysitters). This indicates variation in mothers' perceptions of their children across two or three periods.

Mothers' ratings on each item across three periods were generally positive and consistent across respondents indicating that they perceived their children to be approachable, at ease in unfamiliar settings, rhythmic, adaptable, and predominantly positive in mood. They were more inclined to be temperamentally easy as babies than difficult. As toddlers and 5-to-6 year olds, they were more inclined to be behaviourally uninhibited than inhibited.

In the Harvard Study, children were assessed predominantly in laboratory settings. These assessments were conducted by experimenters/ researchers who were unfamiliar to the children and mothers were not present during all assessments. Children's reactions to unfamiliar toys/objects, people, and separation from mothers were recorded. Given the novel setting, the enforced contact with strangers, and the stress of being separated from mothers while in these situations, it could be expected that children would be more likely to display inhibited behaviours and, therefore, be assessed accordingly. Mothers' ratings in the current study were based on past and present perceptions of their child's behaviour in

normal family/home and away-from-home situations. This may explain why their ratings appear to be more positive than ratings provided in the Harvard Study.

Basis of Mothers' Judgements

The correlations among items at each period (as babies, toddlers, 5-to-6 years) (Tables 4.2-4.4) were submitted to principal component analysis and two factors were rotated to an orthogonal (Varimax) criterion. Four, three, and two eigenvalues for each analysis respectively were found to be greater than 1.0. but a two factor solution was considered to reflect similar dimensions of the data across the three time periods (Table 4.5).

For the first analysis, Factor I is defined by items in set 1-to-7 and might be labelled Body Rhythms and Mood factor. Factor II is defined by items in set 8-to-13 and might be labelled Reactions to People and Situations. For the second analysis (as toddlers) the labels are reversed for Factors I and II. For the final analysis, the solution is less clear - Factor I includes items that formed part of both factors in the earlier two analyses and Factor II is defined by only one item.

The factor analyses suggest that mothers rated their children according to their rhythmicity and mood (Factor I), and the way in which they reacted to people and situations (Factor II). The solution for the 5-to-6 age period implies that mothers may not discriminate children's behaviour into two dimensions but rather have an overall perception that includes many aspects of the child's reactions. Again, the current study varies from the Harvard Study in which children were rated by unfamiliar experimenters/ researchers after participating in six behavioural assessments at 21-22 months.

Table 4.2

Correlations between Items as Babies

Factor	1	2	3	4	5	6	7	8	9	10	11	12	13
1) Health status	-												
2) Mood when awake	420	-											
3) Activity level when asleep	395	577	-										
4) Regularity of sleep times	229	516	499	-									
5) Regularity of meal times	262	271	249	455	-								
6) Level of appetite	247	213	246	215	294	-							
7) Distractability when eating	020	192	062	139	165	154	-						
8) Reaction to family/familiar people	123	032	052	001	016	059	040	-					
9) Reaction to strangers	188	061	097	-006	009	213	-022	300	-				
10) Reaction to unfamiliar settings	153	185	160	115	122	086	-032	298	377	-			
11) Reaction to loud noises	122	080	144	103	-052	-005	097	196	243	269	-		
12) Reaction to new situations	183	147	116	125	106	226	088	286	390	424	236	-	
13) Reaction to grandparents/babysitters	177	192	146	060	008	079	-064	195	287	335	285	406	-

NB: Decimal point removed.

Table 4.3

Correlations between Items as Toddlers

Factor	1	2	3	4	5	6	7	8	9
1) Health status	-								
2) Mood when awake	212	-							
3) Activity level when asleep	-021	073	-						
4) Regularity of sleep times	236	276	063	-					
5) Level of appetite	295	163	134	305	-				
6) Reaction to family/familiar people	125	-049	-060	015	041	-			
7) Reaction to strangers	043	-043	093	054	127	421	-		
8) Reaction to unfamiliar settings	083	167	042	182	087	340	599	-	
9) Reaction to grandparents/babysitters	179	166	045	152	-002	289	302	276	-

NB: Decimal point removed.

Table 4.4

Correlations between Items at 5-6 years

Factor	1	2	3	4	5	6
1) Health status	-					
2) Regularity of sleep times	084	-				
3) Level of appetite	237	142	-			
4) Reaction to family/familiar people	165	078	274	-		
5) Reaction to unfamiliar settings	177	002	190	333	-	
6) Reaction to grandparents/babysitters	162	177	050	368	179	-

NB: Decimal point removed.

Table 4.5

Two Factor Analysis for the Total Year 1 Sample (N = 211)

Variable	As baby		As toddler		Age 5-6	
	I	II	I	II	I	II
1) Health status	555	251	105	612	499	152
2) Mood when awake	772	112	-003	634		
3) Activity level when asleep	738	124	026	217		
4) Regularity of sleep times	768	-012	079	699	013	910
5) Regularity of meal times	613	-042				
6) Level of appetite	465	165	042	649	534	156
7) Distractability when eating	291	-042				
8) Reaction to family/familiar people	-031	571	715	-069	746	094
9) Reaction to strangers	014	696	837	-009		
10) Reaction to unfamiliar settings	124	690	770	156	713	-238
11) Reaction to loud noises	044	527				
12) Reaction to new situations	146	706				
13) Reaction to grandparents/babysitters	082	643	559	207	476	430

NB: Decimal point removed.
% Variance explained: Baby (I=21.42; II=20.00); Toddler (I=23.75; II=20.10); 5-6 (I=30.44; II=18.76).

Consistency of Judgements over Time

Of the items, six were common to each time period so that consistency of behaviour over time could be evaluated. Correlations between the items are reported in Table 4.6.

Significant correlation coefficients were found between:

* each item over all periods indicating that behaviour as a baby would predict behaviour as a toddler;
* each item except for health status between toddler and 5-to-6 year periods indicating that behaviour as a toddler would predict behaviour as a 5-to-6 year old (except health status); and
* for two items only between baby and 5-to-6 years (reaction to family/familiar people and reaction to unfamiliar settings) indicating that behaviour as a baby would not predict behaviour as a 5-to-6 year old except in these two areas.

In general, however, the correlations are modest, so it is difficult to determine the extent to which such predictions might reflect reality.

Table 4.6

Correlations between Six Temperamental Indices Common to the Three Periods

Temperamental Index	Toddler	Age 5-6	
Health status	Baby	429*	104
	Toddler		236
Regularity of sleep times	Baby	423*	199
	Toddler		364*
Level of appetite	Baby	387*	187
	Toddler		450*
Reaction to family/familiar people	Baby	612*	260*
	Toddler		339*
Reaction to unfamiliar settings	Baby	442*	365*
	Toddler		438*
Reaction to grandparents/babysitters	Baby	404*	132
	Toddler		399*

* $P < .05$

These findings are somewhat inconsistent with those of the Harvard Study which suggest that children's behaviours (i.e., the tendency to be inhibited or uninhibited) manifest early in life, are stable, and endure over time. In the present study, the final result does not suggest stable perceptions from baby to young childhood periods.

Incidence of Behavioural Inhibition

Three percent of the 211 children were rated by mothers as consistently inhibited across each of the periods and 29% were rated as consistently uninhibited. The remaining 68% of children were perceived as changing their behaviour across these early periods. Mothers' ratings of these children at 5-to-6 years, however, suggest that 3% were inhibited, 88% were uninhibited, and 9% fell between the two extremes (i.e., they were rated as neither inhibited nor uninhibited).

The figures (mentioned immediately above) differ from figures quoted by Harvard researchers who indicated that approximately 10-15% of American Caucasian children are consistently inhibited while 10-15% are consistently uninhibited in unfamiliar laboratory settings (Kalgan et al., 1988; Rosenbaum et al., 1988; Rosenbaum, Biederman, Hirshfeld, Bolduc, Farone, et al., 1991). Given that the Harvard figures are based on laboratory studies they could be higher than would be expected from studies undertaken using data from regular observations in the home and other "natural" settings. One issue of importance, however, is the reliability of retrospective reports.

Retrospective Reporting

Maternal assessments were used exclusively in the current study. Mothers rated children according to their past and present perceptions of children's behaviour in normal situations (i.e., with family and familiar people, when approached by strangers, when left with grandparents/ babysitters). This method of assessment would seem to represent a more comprehensive picture of a child's behaviour than might be expected in a laboratory even though mothers were rating children retrospectively over two of the three periods - as babies and as toddlers.

The validity of retrospective reporting has been questioned by some researchers. People may forget particular events (especially those that have happened in the distant past), and/or their memories may be biased and reflect current circumstances and ideals (Henry, Moffitt, Caspi, Langley, & Silva, 1994). A retrospective questionnaire methodology is frequently employed, however, to assess the developmental antecedents of children's current behaviours (Abmayr & Day, 1994). Researchers assume that mothers know their children well and can recall their behaviours across different situations and times (Buss & Plomin, 1984). The main findings of a recent study into child temperament and adjustment, conducted when children were 10-to-12 years of age, indicated that "retrospective parent reports of child temperament for the infancy and preschool periods correlated substantially" (Cowen et al., 1992, p. 47). The use of parental ratings as in the current study, therefore, would be expected to be more valid than assessments of children conducted by strangers.

Data from the current study suggest that mothers rated their children's behaviour positively, generally according to two behavioural dimensions (rhythmicity and mood, and reactions to people and situations),

and as not necessarily stable over the three periods.

Results from the both the current study and the Harvard Study have implications for Study Two in which children were identified by preschool teachers as behaviourally inhibited or uninhibited and then rated by mothers and Year 1 teachers. Given that mothers in the current study rated their children positively, mothers of inhibited children would also be expected to rate their children positively.

The following chapter will describe Study 2 in which Group 1 children were identified as behaviourally inhibited by preschool teachers and considered to be at-risk for separation anxiety/school refusal. These children were then compared to a similar group of uninhibited peers (Group 2). Both groups of children were rated by mothers using Questionnaire B. Their individual reactions to the transition from preschool to Year 1 of primary school were then rated by Year 1 teachers at three intervals during Semester 1, Year 1. Teachers also assessed children's social behaviours through to the end of Semester 1.

CHAPTER 5

BEHAVIOURALLY INHIBITED CHILDREN AT-RISK FOR SEPARATION ANXIETY/SCHOOL REFUSAL

Study 2 focussed on two groups of children. Group 1 children had been identified by preschool teachers during their last term of preschool as behaviourally inhibited according to characteristics reported in the Harvard Study while Group 2 children had been identified as behaviourally uninhibited. The proposition underlying the study was that behaviourally inhibited children were at-risk for separation anxiety/school refusal, therefore, Group 1 children:

* as babies, would have manifested temperamental qualities that predisposed them to behavioural inhibition and so be rated by mothers as being difficult babies and timid and withdrawn with unfamiliar people and in unfamiliar settings; and
* on presentation in Year 1, they would have difficulty separating from mothers, settling into school, and initiating interaction with peers and unfamiliar adults.

The results of Study 1, however, suggest that mothers of both behaviourally inhibited and uninhibited children rate their children positively and the latter group may not be as difficult as babies and timid and withdrawn with unfamiliar people and in unfamiliar settings as might be expected. If mother's ratings in Study 2 are similar to those in Study 1 then mothers of both groups would rate their child's behaviour as having changed from when a baby to 5-to-6 years old.

Method

Participants

The mothers and teachers of two groups of children took part in the study. The first group was 25 preschool children. They were identified as behaviourally inhibited by their preschool teachers based upon the inhibited behaviours (i.e., shyness, timidity) that they exhibited. The second (contrast) group was 25 preschool children identified as behaviourally uninhibited by their preschool teachers. Children were attending preschools selected because of their diversity of location and socioeconomic setting. Only 19 out of the 65 preschools contacted at the beginning of the Term 4, 1996, identified children for the study. Three preschools were within four kilometres of the Brisbane city centre, seven were within a 5-to-10 kilometre radius of the city centre, and nine were within an 11-to-32 kilometre radius of the city centre. Thirteen preschools were in the state system, two were in the private system, and four were in the Catholic system.

Difficulties were experienced in procuring behaviourally inhibited and contrast children for the study. The reasons are as follows:

* eleven preschool teachers had recommended to parents that the identified behaviourally inhibited children should repeat preschool in the following year and all parents accepted the recommendation;
* four teachers would not participate in the study because they were already involved in other studies;
* three teachers were not comfortable about asking parents to participate in the study; and
* twenty-eight teachers reported having no children under their care who fitted the criteria for behavioural inhibition.

Of the 62 families approached to take part in the study, 50 expressed

their willingness to participate. All of the Year 1 teachers consented to participate in the study. Data relating to the children, mothers, and teachers are presented below.

Children. The inhibited children (Group 1) had displayed behaviours such as fearfulness, timidity, and shyness for over 3-to-4 months during their last term of preschool. This group consisted of 13 boys and 12 girls. With the exception of one boy born towards the end of 1990, all other children were born in 1991. Although the boy born in 1990 could have commenced preschool in 1995, his mother chose not to send him until 1996 believing that he was too immature and introverted. The uninhibited children (Group 2) consisted of 12 boys and 13 girls who were matched as closely as possible with peers in Group 1 of a similar age, gender, place in the family, and parental status (i.e., intact family, single parent family). All children, apart from one boy born towards the end of 1990, were born in 1991. The boy born in 1990 could have started preschool in 1995, however, his mother elected not to send him until 1996 reporting that she enjoyed his company and would miss him so kept him home for an extra year.

Mothers. Group 1 informants were 24 mothers and one grandmother who were the primary caregivers of the behaviourally inhibited group. The mothers' ages ranged from 29-to-42 years. The grandmother was 46 years. Five mothers were in their 20s, 13 in their 30s, and six in their 40s. Nineteen carers were involved in home duties, two were in full-time employment, and four were in part-time employment. Group 2 informants were 25 mothers who were the primary caregivers with ages ranging from 26-to-44 years. Four mothers were in their 20s, 15 in their 30s, and six in their

40s. Twenty-one listed home duties as their occupation, while two listed full-time employment, and two listed part-time employment.

Teachers. Of the 19 preschool teachers, two were male; 15 were trained in Queensland institutions, one interstate, and one overseas. Their years of teaching experience ranged from 5-to-27 years. They had known the identified children for a minimum of eight months. Of the 50 Year 1 teachers who participated in the study all were female; 45 were in the state system and five in the Catholic system; 38 were trained in Queensland institutions, eight interstate, and four overseas. Their years of total teaching experience ranged from 1-to-35 years while their years of teaching Year 1 ranged from 1-to-19 years.

The Instruments

Questionnaire A. Questionnaire A was used again to seek information from preschool teachers about children in their last term of preschool. Teachers were asked to identify children who had watched peers rather than interact with them; retreated from unfamiliar peers/adults; spoke softly and infrequently; lacked confidence and were not assertive; and sought comfort from mothers or familiar adults. These behaviours must have been displayed consistently for frequent and/or prolonged periods over 3-to-4 months. The children were then matched as closely as possible with children (also in their last term of preschool) who displayed few, if any, of the inhibited behaviours listed immediately above. Both groups of children were then rated on 12 items related to their behaviour and social interaction (i.e., makes peer friendships easily, becomes involved in group activities, separates easily from mother).

Questionnaire B. This instrument was also used again to collect information from mothers about children's temperamental style over three periods in the children's lives and also sought information from mothers about their childhood history, school functioning, present functioning, parenting style, and emotional health (Appendix C). Mothers were asked if they had been anxious at school, made friends easily, and attended school regularly. They were also asked if they found it difficult to separate from their child, had a close relationship with their own mother, and were protective and/or encouraged independence in their child.

Teachers' questionnaire. The questionnaire (Appendix D) consisted of three parts. Part A sought information about children's school adjustment and social interaction during the first two weeks of Year 1 (i.e., separated easily from mother on arrival at school, interacted spontaneously with peers, was at ease in new situations). Part B sought information about children's school readjustment and social interaction after the Easter holiday (i.e., settled back into school easily, initiated friendships with peers, became involved in risk-taking activities). Part C sought information about mothers' involvement at school (i.e., mother regularly involved in school activities) and children's social interaction, school behaviours, and behavioural style (i.e., prefers to play alone, attends school regularly, is anxious and/or cautious).

Procedure

Questionnaire A was distributed to 62 preschools in early October, 1996. Prior to the end of the 1996 preschool year, mothers of identified behaviourally inhibited and uninhibited children were given letters by the

preschool teachers from the researcher explaining the study, plus a consent form and reply paid envelope for its return. The involvement of the preschool teachers in approaching the mothers on the researcher's behalf ensured that confidentiality was maintained. Unless mothers returned the consent forms, their names and those of their children were unknown to the researcher. Mothers were contacted as consent forms were returned and times arranged to forward Questionnaire B and conduct either telephone or face-to-face interviews. Interviewing took place over an 8-week period from the end of March to the end of May, 1997.

In the first week of the 1997 school year, letters outlining the study, Part A of the teachers' questionnaire, and copies of Ethical Clearance for the study from both Education Queensland and Brisbane Catholic Education were forwarded to schools. Principals and teachers were assured that parental consent for their child's participation in the study had been given and that all information supplied by teachers would be strictly confidential. Telephone interviews were conducted with participating Year 1 teachers after they had returned Part A of the questionnaire. Part B of the questionnaire was forwarded in the week following Easter, 1997, and telephone interviews conducted with teachers on the questionnaire's return. Part C of the questionnaire was forwarded in the first week of the second semester, 1997. Telephone interviews with teachers followed. Data collected via telephone and face-to-face interviews with mothers and Year 1 teachers are presented below.

Results and Discussion

Mothers' Perceptions of their Children

Six items in Questionnaire B were common to each period so that stability of behaviour across time could be measured.

Group 1. The means and standard deviations of Group 1 mothers' perceptions of their child's behaviour are presented in Table 5.1. Correlations between the six items are presented in Table 5.2.

Table 5.1

Factors Associated with Children's Temperament across Three Periods

Factor	As Baby M	SD	As Toddler M	SD	Age 5-6 M	SD	P
Health status	1.3	.48	1.2	.38	1.1	.28	.12
Mood when awake	1.2	.38	1.4	.49			.13
Activity level when asleep	1.2	.38	1.3	.56			.16
Regularity of sleep times	1.4	.51	1.3	.68	1.3	.56	.58
Regularity of meal times	1.3	.46					
Level of appetite	1.6	.58	1.7	.69	2.0	.65	.00*
Distractability when eating	1.8	.60					
Reaction to family/familiar people	1.7	.63	1.6	.58	1.3	.46	.01*
Reaction to strangers	2.0	.46	2.2	.50			.10
Reaction to unfamiliar settings	1.8	.60	2.1	.44	2.0	.29	.02
Reaction to loud noises	1.7	.48					
Reaction to new situations	2.0	.87					
Reaction to grandparents/babysitters	1.8	.62	1.6	.76	1.6	.82	.23

NB: Ratings were 1 = positive; 2 = neutral; 3 = negative.
* P < .006

Analyses of variance with repeated measures were undertaken for each of the items associated with children's temperament (e.g., mood when awake, activity level when asleep) and the levels of significance are shown in Table 5.1. The Bonferroni adjustment was made to the level of significance producing a critical probability level of .006. As can be seen

two items reached the level of statistical significance (i.e., level of appetite, reaction to family/familiar people). This indicates variation in mothers' perceptions of their children across the two or three periods.

Mothers' ratings of children's behaviour across the three periods were generally positive for all items except three (i.e., reaction to strangers, reaction to unfamiliar settings, reaction to new situations). This indicates that mothers perceived their children as predominantly positive in mood, rhythmic, and at ease with family and familiar people but hesitant with strangers, in unfamiliar settings, and in new situations. Hesitancy to interact with unfamiliar people, reluctance to approach (or actual retreat from) strangers, and hesitancy and/or distress in unfamiliar settings and new situations are major signs of behavioural inhibition. Therefore, it would appear that Group 1 children manifested signs of behavioural inhibition as reported by laboratory researchers.

Table 5.2

Correlations between Six Temperamental Indices Common to the Three Periods

Temperamental Index	Toddler	Age 5-6	
Health status	Baby	-065	-202
	Toddler		-129
Regularity of sleep times	Baby	-010	-077
	Toddler		305
Level of appetite	Baby	360	443
	Toddler		654
Reaction to family/familiar people	Baby	738*	180
	Toddler		168
Reaction to unfamiliar settings	Baby	114	000
	Toddler		000
Reaction to grandparents/babysitters	Baby	490	196
	Toddler		768*

* P < .05

Significant correlations were found between only two items; reaction to family/familiar people during baby and toddler periods and reaction to grandparents/babysitters during baby and 5-to-6 year old periods.

It would appear that mothers perceived their children's behaviour as changing over the three periods which is contrary to laboratory study findings which suggested that children's behaviours remain stable. Mothers' perceptions of their children's behaviour compared to preschool teachers' perceptions also differed. Of the 25 children identified as behaviourally inhibited by preschool teachers, mothers rated only three children as being consistently inhibited and two as consistently uninhibited across the three periods, 10 (40%) as inhibited and 12 (48%) as uninhibited at age 5-to-6 years, and three (12%) as neither inhibited nor uninhibited (i.e., their behaviour fell between the two extremes). Teachers' ratings at the end of the first semester of Year 1, however, supported the preschool teachers' ratings. Twenty-three children were rated as inhibited and two as uninhibited (the latter children were rated as uninhibited by their mothers). At the end of Semester 1:

* four children were still concerned when separating from mothers, one child still attempted to follow mother; and
* 13 children were hesitant when interacting with peers, 14 were still cautious when interacting with the teacher, 21 still took time to adjust to new situations.

Of the 25 families in Group 1, 24 were intact with no other relatives living within the family home. One family consisted of grandmother (the primary caregiver), uncle, and the child. Seven children (28%) were the eldest, 17 children (68%) were the youngest or later born in the family, and one child (4%) was an only child.

Group 2. The means and standard deviations of Group 2 mothers' perceptions of their child's behaviour are presented in Table 5.3. Correlations between the six items are presented in Table 5.4.

Table 5.3

Factors Associated with Children's Temperament across Three Periods

Factor	As Baby M	SD	As Toddler M	SD	Age 5-6 M	SD	P
Health status	1.4	.50	1.3	.48	1.0	.20	.00*
Mood when awake	1.2	.52	1.5	.71			.38
Activity level when asleep	1.4	.70	1.4	.77			.65
Regularity of sleep times	1.4	.70	1.8	.96	1.1	.44	.00*
Regularity of meal times	1.3	.56					
Level of appetite	1.5	.71	1.4	.58	1.1	.33	.01*
Distractability when eating	1.8	.50					
Reaction to family/familiar people	1.3	.54	1.1	.28	1.0	.20	.00*
Reaction to strangers	2.0	.35	1.8	.55			.27
Reaction to unfamiliar settings	1.4	.57	1.6	.65	1.4	.50	.10
Reaction to loud noises	1.7	.48					
Reaction to new situations	1.9	.76					
Reaction to grandparents/babysitters	1.8	.72	1.4	.51	1.1	.33	.00*

NB: Ratings were 1 = positive; 2 = neutral; 3 = negative.
* P < .006

Analyses of variance with repeated measures were undertaken for each of the items associated with children's temperament (e.g., reaction to strangers, health status) and the levels of significance are shown in Table 5.3. The Bonferroni adjustment was made to the level of significance producing a critical probability level of .006. As can be seen there are five items which reached the level of statistical significance (i.e., health status, regularity of meal times, level of appetite, reaction to family/familiar people, reaction to grandparents/babysitters). This indicates variation in mothers' perceptions of their children across the two or three periods.

Mothers' ratings on each item across three periods were generally

positive for all items except reaction to strangers as a baby. This indicated that mothers perceived their children to be approachable, at ease in unfamiliar settings, rhythmic, adaptable, and predominantly positive in mood but hesitant with strangers when a baby though not hesitant with strangers when a toddler. Group 2 children were inclined to be temperamentally easy as babies, behaviourally uninhibited as toddlers, and more positive as 5-to-6 year olds.

Table 5.4

Correlations between Six Temperamental Indices Common to the Three Periods

Temperamental Index	Toddler	Age 5-6	
Health status	Baby	736*	272
	Toddler		298
Regularity of sleep times	Baby	123	-161
	Toddler		356
Level of appetite	Baby	628	429
	Toddler		147
Reaction to family/familiar people	Baby	678*	662*
	Toddler		692*
Reaction to unfamiliar settings	Baby	671*	413
	Toddler		648
Reaction to grandparents/babysitters	Baby	528	299
	Toddler		417

* $P < .05$

Significant correlations were found between health status, reaction to family/familiar people, and reaction to unfamiliar settings between the baby and toddler periods, but only one item reaction to family/familiar people between baby, toddler, and 5-to-6 years. Again, these findings are generally contrary to laboratory studies and demonstrate a greater stability

in these children's behaviour than their inhibited peers.

Mothers rated 10 of the 25 children as being consistently uninhibited across the three periods. Their ratings of their children's behaviour at 5-to-6 years were the same as the Year 1 teachers' ratings; 23 (92%) children were uninhibited and two (8%) inhibited. At the end of Semester 1:

* one child was still a little concerned when separating from mother; and
* two were hesitant when interacting with peers, one was still cautious when interacting with the teacher, two took time to adjust to new situations.

Of the 25 families in Group 2, all were intact with no other relatives living within the family home. Twelve children (48%) were the eldest, 11 children (44%) were the youngest or later born in the family, and two children (8%) were only children.

Maternal Self-Ratings

Both Group 1 and Group 2 mothers were asked to evaluate their own past and present functioning by choosing one of four possible ratings or one of five possible ratings for items of the questionnaire. The means and standard deviations of Group 1 mothers' perceptions of their past and present functioning are presented in Table 5.5. The means and standard deviations of Group 2 mothers' perceptions of their past and present functioning are presented in Table 5.6.

There appears to be only one item on which both Group 1 and Group 2 mothers' ratings differ. Group 1 mothers rated themselves as being more anxious at school than Group 2 mothers. Both groups rated themselves as being quite positive about school, they attended regularly, and usually made peer friendships easily. Both groups generally found it difficult to

separate from their children, shared the parenting role with their husbands, and had a positive relationship with their own mothers although their parenting styles differed from their mothers'. Both groups were sometimes anxious about their children and frequently protective of them.

Table 5.5

Group 1 Mothers - Past and Present Functioning

Responses	M	SD
Reaction to school	2.1	.91
School attendance	1.3	.46
Reaction to separating from child	2.4	1.06
Fathers' role in parenting	2.0	1.20
Similarity of parenting style to own mothers'	2.3	.68
Relationship with mother	1.6	.78
NB: Ratings were 1 = positive; 2 = quite positive; 3 = quite negative; 4 = negative.		
Became anxious at school	2.4	1.19
Made peer friendships easily	2.8	1.04
Anxious as a parent	2.2	1.11
Protective of child	4.0	1.02
NB: Ratings were 1 = rarely; 2 = sometimes; 3 = usually; 4 = frequently; 5 = always.		

Again, these findings seem to be inconsistent with major studies conducted in the United States on behavioural inhibition which showed that mothers of behaviourally inhibited children are anxiety-prone and overprotective (Biederman et al., 1990; Hirshfeld et al., 1992; Rosenbaum et al., 1988).

Table 5.6

Group 2 Mothers - Past and Present Functioning

Response	M	SD
Reaction to school	2.0	.84
School attendance	1.5	.77
Reaction to separating from child	2.4	.87
Fathers' role in parenting	2.2	.91
Similarity of parenting style to own mothers'	2.6	.91
Relationship with mother	2.0	.96

NB: Ratings were 1 = positive; 2 = quite positive; 3 = quite negative; 4 = negative.

Became anxious at school	1.6	.76
Made peer friendships easily	2.9	.81
Anxious as a parent	2.0	.98
Protective of child	4.2	.88

NB: Ratings were 1 = rarely; 2 = sometimes; 3 = usually; 4 = frequently; 5 = always.

In summary, it was predicted in Study 1 that mothers' ratings of children in the current study would be similar to mothers' ratings in Study 1. One difference was found in the current study: Group 1 mothers rated children positively on all items except for reaction to strangers, reaction to unfamiliar settings, and reaction to new situations. This appears to indicate that Group 1 children manifested signs of behavioural inhibition. This has implications for Study 3 in which case studies of six former school refusal children/adolescents will be presented. Given that Group 1 mothers rated their children as manifesting some signs of behavioural inhibition, it would be expected that Study 3 mothers would also rate their children/adolescents (as babies to 5-to-6 years) as having manifested signs of behavioural inhibition.

The following chapter will describe Study 3 in which interviews were conducted with both mothers and present teachers of six former school

refusal children/adolescents. Mothers were asked to rate their children's/ adolescent's temperament as a baby, at preschool, in the early school years, and at present. They were also required to rate their family dynamics and functioning, interactions between family members, and family history (particularly their own past and present history and their relationship with their own mother). Teachers were asked to assess children's/adolescent's current school functioning, in particular, their school attendance, how they interacted with teachers and peers, and whether they were anxious at school.

CHAPTER 6

CASE STUDIES: FORMER SCHOOL REFUSAL CHILDREN & ADOLESCENTS

Study 3 focused on six children/adolescents who had been treated for school refusal in the past. As reported in Chapter 2, mothers may transmit to children trait-like predispositions to develop anxiety. Children may also have a temperamental trait that predisposes them first to difficult behaviours as a baby followed by behavioural inhibition and anxiety, in particular, separation anxiety. As temperamental traits manifest early in life and are reported to be stable over time, it would be expected that the former school refusers who were participants in this present study would have displayed certain behaviours from when a baby to the present time.

Mothers were asked to describe their children's/adolescent's behaviour over three periods (as baby and toddler, and at present). Questions were related to children's/adolescent's mood, rhythmicity, adaptability, and reactions to people and situations. Teachers were asked to describe children's/adolescent's school behaviours (i.e., anxiety, confidence, distractability), interactions with familiar and unfamiliar peers and teachers, and school attendance. If behavioural inhibition is a precursor to separation anxiety followed by school refusal, then the six children/adolescents would have been irritable and negative as babies, shy and fearful as toddlers, introverted and cautious at kindergarten/ preschool, and anxious and avoiding at school.

As reported in Chapter 3, mothers of school refusal children are often dependant on their own mothers, anxious, overprotective of their school refusal child, and have experienced anxiety at school and/or difficulty settling into school as children. Mothers, therefore, were asked

to describe their own behaviours as a child (i.e., their reactions to school, attendance, peer relationships), their relationship with their own mother, and their style of parenting.

Method

Participants

The Brisbane North and Caboolture Child and Youth Mental Health Service (CYMHS) regions were approached to facilitate the study. It was a condition of the management and therapists of both regions that confidentiality would be maintained. No former school refusal children or adolescents were to be interviewed or involved directly in the study. Mothers and teachers were to provide all data. No personal details were to be provided to the researcher and participation in the study proceeded only when consent forms were signed by mothers or caregivers.

Former school refusers were identified through the CYMHS clinics at Caboolture and the Royal Children's Hospital, Brisbane (one of four clinics in the Brisbane North region willing to participate in the study). Both clinics requested that letters outlining the study (Appendix E) and consent forms (Appendix F) be forwarded to them. It was then up to therapists to approach mothers of children and adolescents who they had treated for separation anxiety/school refusal in the past. Thirty letters and consent forms were distributed to potential participants. The mothers were asked to discuss the study with the identified former school refusers before agreeing to participate. Only 6 consent forms were signed and returned to the researcher. The low level of response can be attributed to the unwillingness of the identified school refusers to:

* permit contact with their present school teachers - in particular,

those teachers unaware of their past school refusal problems; and

* allow mothers to discuss their personal history with the researcher because of their fear of being identified once the study was presented in written form.

It was expected that the 6 former school refusers would have presented with separation anxiety/school refusal during one of following time periods when separation anxiety/school refusal is reported as being most prevalent:

* between 5 and 7 years;
* between 11 and 12 years; and
* between 13 and 14 years.

In general, between ages 5 and 7 years, school refusers are reported to be less psychologically disturbed than children in the two older age groups. The onset of their school refusal is sudden (frequently precipitated by a specific event) and they respond to treatment positively because their school refusal behaviour is not entrenched. School refusers between ages 11 and 12 years are generally more disturbed. The onset of their school refusal is more gradual and occurs over a longer period of time. They are reported to respond to treatment positively if they are preadolescent. Between ages 13 and 14 years, school refusers manifest more serious personal pathology. Reports suggest that they have been disturbed from an early age, the onset of their of school refusal is insidious, and they respond to treatment poorly because their school refusal behaviour is so entrenched and severe.

The ages of the 6 former school refusers on first presentation to a CYMHS clinic ranged from 7-to-11 years. Five had been treated as In-patients at the Child and Family Therapy Unit (CFTU) at the Royal Children's Hospital, Brisbane, and one had been treated at the Caboolture

CYMHS which offers Out-patient treatment only. Their length of treatment, including follow-up support after return(s) to school, ranged from 7 weeks to 7 years.

Interview Schedules

As school refusal is generally associated with maternal behaviour patterns, mothers were requested to answer questionnaires and participate in the following interviews. The questionnaire (Questionnaire B) consisted of Parts A and B was distributed to mothers of the former school refusers. Part A sought responses about children's and adolescent's behavioural style during three periods in their lives, as a baby, toddler, and at the time of the interview. Questions pertaining to each time period were similar (i.e., were children at ease in unfamiliar situations, were children able to separate from mother). Part B, sought information about the mother's school attendance, peer relationships, and her relationship with her own mother.

The teachers' questionnaire (Appendix G) sought information about the target children's social interaction, school behaviours, behavioural style, and maternal involvement in school activities. Questions were asked about school attendance, peer friendships, the extent of anxiety displayed by children and adolescents, and their participation in group activities.

Procedure

Questionnaires were posted in April, 1997, to the mothers who had agreed to participate. Phone calls were made the following week to arrange interviews. Letters outlining the study, plus teachers' questionnaires, were sent to principals of the schools attended by 3 of the 6 participating former school refusers also in April, 1997. The other 3 participants were no longer

attending school. Telephone contact was made with principals the following week to arrange times for teacher interviews. Face-to-face interviews were conducted with mothers, teachers, and school guidance officers residing in South East Queensland while a telephone interview was conducted with the school counsellor residing in New South Wales (School guidance officers/ counsellors advise students on academic and occupational choices or on personal problems).

All participants (mothers and teachers) were assured that confidentiality of information would be guaranteed, the issue of confidentiality being particularly sensitive in mental health and educational facilities.

Results

Data collected from the informants are presented in the following case studies. The participants' names have been changed to ensure anonymity.

Study 1: Daniel

Daniel lived in a large country town south of Brisbane. His family consisted of mother, father, maternal grandmother, two brothers, sister, and sister's baby, all of whom were living in the family home. Daniel was the youngest in the family. His nearest sibling in age was a brother six years his senior.

Early history. Up until 12 months of age, Daniel suffered from reflux and was unsettled during the day and at night. His sleep patterns, however, were regular. He would not wake in the night, but toss and turn, then settle when mother rubbed his back. His eating patterns were irregular

and he refused to try new foods preferring to eat only one type of breakfast cereal, and a limited range of fruit and vegetables (i.e., bananas, apples, carrots, potatoes, peas). He was easily distracted by interaction between family members and mother during meal times and would refuse to be fed by anyone other than mother. He was cautious with family members and friends and clung to mother when approached by strangers. He was rarely left with anyone other than maternal grandmother, and even when left with her, he was unhappy and would take a long time to settle. He would turn away from grandmother when she tried to comfort him and cry until mother returned.

As a toddler, Daniel suffered from frequent asthma attacks and required constant attention from mother. Mother also stated, however, that he liked to be close to her at all times and was quite demanding of her time - he would follow her from room to room, climb onto her lap when she sat down, and want her to play with him or read to him. He continued to retreat from strangers and was unhappy when left in the care of grandmother. He still took time to settle at night. Mother would give him a bottle of milk and stroke his head or arm until he went to sleep.

School refusal history. Daniel was referred to CFTU by his school Guidance Officer when he was 7 years of age and in Year 3. His school attendance had been minimal in the preceding six months. He had experienced separation anxiety/school attendance problems since beginning preschool at four years of age. On arrival at preschool each morning he had clung to mother and cried, he had to be held by preschool staff until mother had left to prevent him from running after her. Mother continued to take Daniel to school until the end of Year 1. For the first four weeks of that year he was held by the teacher until mother had left the school grounds. From

Year 2 onwards, he had gone to school with his older brother who attended the nearby high school. His school attendance in Year 1 was irregular. He missed (on average) one day a week and in Years 2 and 3 missed one to two days a week. He would complain of feeling sick or of having a stomach ache and mother would keep him home.

During Daniel's four week admission to CFTU, he attended the hospital school and found it difficult to settle to written tasks and would not read to the teacher or in front of his peers (the teacher thought that Daniel was conscious of his lack of ability in those areas). His verbal skills were above average. Although Daniel was in Year 3 - appropriate for his age - he was functioning at an early Year 2 level in both mathematics and language.

Daniel attended daily sessions with his therapist (a psychologist) at CFTU. During these sessions he was helped to overcome his separation anxiety by talking about his fears of leaving mother and his fears about school. When mother left CFTU after her daily visit, he was encouraged to use strategies (suggested by the therapist) to help ease his separation from her. Mother also attended counselling sessions with the therapist. When she and Daniel were able to separate without prolonged clinging to each other, and Daniel crying and trying to follow mother, re-integration to Daniel's home school was organised. Re-integration took place from CFTU over a two week period. The re-integration program was as follows:

Day 1: Daniel to school with hospital school's liaison teacher. Liaison teacher sat at back of class, returned Daniel to CFTU at 3pm.

Day 2: To school with liaison teacher. Liaison teacher sat outside class till 10:30. Picked up at 3pm by CFTU staff - back to CFTU.

Day 3: To school with liaison teacher, Daniel walked to class by himself from school gate. Picked up at 3pm by CFTU staff - back to CFTU.

Day 4: To school with liaison teacher, dropped off at school gate. Picked up at 3pm by CFTU staff - back to CFTU.

Day 5: To school with liaison teacher. Picked up at 3pm by parents, home for weekend. Back to CFTU Sunday evening with parents.

Days 6 to 10: With liaison teacher to class teacher's home (15 kilometres from CFTU). To school with class teacher. Returned to CFTU after school by parents.

Daniel was discharged from CFTU on Day 10 and went from home to school from the next day onwards. He continued his schooling until the end of Year 7 although he was admitted to CFTU on five more occasions when he found it difficult to return to school after school holidays. Each admission was for one night only. He was re-integrated to his home school without incident and put on a contract by his therapist. The contract stated that he would be re-admitted to CFTU for a longer period if he failed to attend school on the following day. Daniel continued to see his therapist each month to discuss ways in which he could master his continuing separation anxiety and school fears. When his school refusal became more severe in Year 8, his parents decided to withdraw him from therapy at CFTU and take him to their local CYMHS clinic because it was much closer.

Present school functioning. Daniel is 14 years of age and in Year 9, however, he no longer attends the local high school. He had found the transition from primary school to high school extremely stressful and had spent most of the first semester of Year 8 at home. At the beginning of the second semester, he had started Distance Education and continued his schooling in that way. His mother reported that he was not totally committed to his studies and would probably cease as soon as he turned 15 years. She

also reported that Daniel was never as happy and settled at school as his siblings. He always found school work difficult and received help from the Learning Support teacher in Years 2 through 5. His attendance at school was never regular and he frequently complained of headaches and stomachaches. Mother said that she had kept him home on these occasions.

Present home and social functioning. Daniel still suffered from asthma but "he had grown out of it to a certain extent," according to mother. He used a variety of delaying tactics as his bedtime approached and still took time to settle. When he was younger (between 6 and 11 years) he would come into his parent's bedroom at night and ask if he could bring his mattress and sleep on the floor. This was never allowed, although during some of his asthma attacks he was allowed to come into the parent's bed until he settled.

Daniel still preferred not to interact with family friends and adults and children he knew outside of the family. Mother described him as "a loner." He preferred to be with his family and was very fond of his sister's baby son. He was very hesitant with strangers and remained ill at ease when he attended social functions with family members. He had no friends of his own age. Although some family members had tried to encourage him to join organisations or clubs where he would meet other adolescents, they were unsuccessful. He remained very cautious in unfamiliar situations and was still anxious when separated from mother. He expected to work with his father and one of his older brothers in the family business when he turned 15 and continue to live at home. His parents were happy for this to occur - mother described the family as being very close and supportive of each other.

Study 1: Daniel's Mother, Teresa

Teresa was the eldest of six children. She had one sister and four brothers all of whom were living in Queensland and all of whom she saw frequently. Her mother was widowed and had lived with her from the time that Daniel was born.

Early history. Teresa reported that as a child she had few friends, was quite introverted, and rarely took risks (i.e., climbed trees, rode horses). She was always anxious about achieving academically at school. She was quiet compared to her younger siblings who were outgoing and bossy, especially her sister who was closest to her in age. Even though she was the eldest she felt that she tagged along after the others. She found it difficult to settle into school but attended regularly because her parents "made her go." She and her siblings were only allowed to stay home if their temperatures were above normal. She went to a small country school and would get upset because the teacher compared her school performance to her younger sisters'. Even at the present time, she still perceived herself as quieter, less confident, and less competent.

Recent history. Teresa described her own health as excellent but the grandmother had high blood pressure and had recently had two strokes. Teresa found this, and the presence of a rather unsettled baby in the house, quite a strain. She also admitted that she worried about Daniel's isolation from his peers although she liked to have him at home and still found separating from him concerning. She was rarely separated from any of her children when they were little and found separating from Daniel when he was young even more concerning - probably because he was the youngest by

six years, quite reliant on her, and she enjoyed his company. It was difficult for her when he went to preschool and school but she thought that "it was just a natural motherly reaction."

Parenting style. Teresa thought that her parenting style was very different to her own mother's although she described their relationship as "very close." Her mother was very loving and caring but had worked full-time, and very long hours, with the father in a family business. As a result, the children (especially mother as eldest) had a great deal of responsibility. They were left alone in the mornings and had to get themselves off to school. At night they came home to an empty house. Teresa decided that when she had children she would stay at home to spend as much time with them as possible. She also made a conscious effort to talk to her children and listen to their problems - her mother had always been too busy.

As a mother herself, Teresa tried to be tolerant, caring, and sensitive of her children's feelings. She felt that she was affectionate towards her children and encouraged them to be independent although she was protective of them (especially Daniel). She reported that she was more involved in the parenting role than her husband. This did not concern her as he helped when he could but was extremely busy with the family business and "at least the children had one parent there all the time."

In summary, Daniel had been demanding of mother's time and attention as a baby and as a toddler. He had been cautious with family friends and hesitant with unfamiliar people from when he was a baby until the present time and still preferred to be at home with mother and his family rather than mix with peers or attend social functions or clubs.

Study 2: Paul

Paul lived in a small country town in northern New South Wales with his mother, father, and three older brothers (two were step brothers). When Paul's school refusal became severe and the family doctor who was treating him thought that he could do no more to effect a return to school, he referred Paul to CFTU for In-Patient treatment. After Paul had been an In-patient for three weeks, his mother decided to move to Brisbane permanently. She separated from Paul's father and he remained in New South Wales with Paul's brothers.

Early history. Paul's mother described him as "a fearful personality from birth but placid and contented." He was healthy, his sleep patterns were regular, and he was restful during the night up until the age of 7 months when the family began a year long holiday in Europe. He then became unsettled during the day and began to wake in the night and stay awake even though mother would feed him and try to rock him to sleep. His eating patterns were irregular, he was distractable when eating, and would refuse new foods preferring to eat only yoghurt. Mother breastfed him until he was 18 months old. He was cautious with family members and people familiar to the family, and would stop playing and vocalising when approached by strangers. He always stayed close to mother and was unhappy when she left him (on the odd occasion) with babysitters. He would cry when she left and take up to half an hour to settle. When she returned, he would cling to her and refuse to interact with anyone, even family members, for at least 15 minutes.

As a toddler, Paul was healthy. Mother reported that he needed constant attention during the day, however, because "he had to be beside

me at all times and have me play with him." He still woke, at least once, during the night and his appetite was poor. He still took time to approach unfamiliar adults and children, was withdrawn with people he knew, and stayed close to mother when in unfamiliar situations. When left with babysitters, he was unhappy and would stand at the door waiting for the mother's return.

When Paul was 3 years and 6 months, mother went back to work full-time and he went into child care. Both Paul and mother found it difficult to separate because they had been separated very rarely up until that time. Mother also stated that she felt very guilty about leaving Paul when "he was so dependent on me."

School refusal history. At presentation at CFTU, Paul was 9 years of age and in Year 4. His separation anxiety/school refusal had been a long standing problem. He had found it very difficult to separate from mother at preschool, had clung to her and cried. He had remained tearful after she left until the preschool teacher engaged him in play. He settled into Year 1 after 4-to-5 weeks but had been tearful and had clung to mother each morning. He had then gone into class with the teacher's help. His school attendance in Year 1 and Year 2 was irregular. He only attended for 2 or 3 days a week. In the first semester of Year 3, his attendance deteriorated and in the second semester of Year 3 and the first two months of Year 4 he ceased attending altogether. He had also had encopresis for the past six years and soiled up to four times a day.

Paul was an In-patient at CFTU for five weeks. He attended the hospital school for four weeks but was reluctant to attend initially. He had to be assisted into class by CFTU staff on the first few mornings. Once he

settled into the school routine he participated well in group activities and responded positively to praise. He had a wide general knowledge and joined into oral activities with enthusiasm, however, he was reluctant to participate in written activities. His spelling was poor, and his knowledge of language rules was limited.

Paul attended daily sessions with his therapist (a psychiatric registrar) at CFTU and also participated in a bowel training program at The Royal Children's Hospital. When he and mother no longer had problems separating after mother's daily visits, and Paul was no longer soiling, school re-integration to a large state school in the outer suburbs of Brisbane was planned. Paul was taken to school, in the week prior to his re-integration, for an orientation visit where he met his teacher and spent 10 minutes in the class. His re-integration program was as follows:

Day 1: Paul to school with hospital school's liaison teacher. Liaison teacher walked him to class, stayed outside class till he was settled. Picked up at 3pm by CFTU staff - back to CFTU.

Days 2 to 4: Paul to school with liaison teacher, Paul walked to class from school gate by himself. Picked up at 3pm by CFTU staff - back to CFTU.

Day 5: Paul, mother, liaison teacher to school. Liaison teacher modelled for mother dropping Paul at school gate, staying in car and keeping goodbyes short. Paul picked up at 3pm by mother, home for weekend. To school from home with mother the following Monday.

Paul was discharged from CFTU on the Monday afternoon. He continued to see his therapist each week for three months after his discharge, then each month over the following year. Over the following two years, he only saw his therapist if he felt the need to discuss any school or

personal problems. He did not require readmission to CFTU for separation anxiety/school refusal after his initial five week admission.

Present school functioning. Paul is 14 years old and in his first year of high school in New South Wales. Mother had been expecting Paul to find the transition to high school difficult. Towards the end of Year 7 he had begun voicing his concerns about how he would manage high school when his closest friends were not going to the same school as he was. Mother decided, therefore, to send Paul back to New South Wales to live with his father so that he could attend the local high school with his older brother. Mother believed that the transition would not be as difficult for Paul with his brother's support. He had now attended the local high school for three terms and had settled into the various classes quite easily. His attendance was regular. He was cautious with teachers/adults he knew and rather reticent with unfamiliar teachers/adults (i.e., supply teachers). Although Paul appeared to initiate friendships with his peers quite easily, he was hesitant in his interactions with them. He had a few friends but did not have a particular peer group. His teachers described him as a quiet anxious boy who was always obedient and eager to please. He was hesitant to assert himself in group situations and dependent on adult support in those situations within the classroom setting.

Present home and social functioning. Prior to his move to New South Wales, Paul still lacked self-confidence and remained ill at ease in unfamiliar situations. He no longer had problems settling at bedtime and was sleeping through the night. His appetite was good but he ate a limited selection of foods (i.e., from the school tuck shop and take away meals at night as

mother worked full-time in her partner's business). He was still concerned when cared for by anyone other than mother - she only left him when she was unable to take him with her.

Mother described Paul as "not very sociable." He had the same few friends since Year 4 and was still hesitant in his interactions with them. He appeared to be happy to go to their homes, or have them come to his, after school and on weekends. He was also quite happy for them to stay overnight at his home but was not happy about staying overnight at theirs. He still took time to interact with family friends and remained cautious and ill at ease with strangers. Paul's home and social functioning in New South Wales remains unknown to the researcher. Mother had been willing to give permission for high school contact but not for contact with the father.

Study 2: Paul's Mother, Olivia

Olivia was the eldest of four children. She only saw her mother, who lived in Western Australia, every 3-to-4 years but corresponded with her regularly. Contact with the rest of her family was limited. She saw her father, sister, and two brothers (all residing in New South Wales) approximately every three years and contacted them rarely by telephone or letter.

Early history. Olivia described herself as quiet and cautious as a child. She had found it difficult to make friends and preferred to play with her siblings both at home and at school. She could remember crying and having tantrums when her mother took her to preschool. She did not like her mother leaving her there and after a while mother stopped taking her because they both became so upset. In Years 1 and 2 she pretended to be

sick at school and was often sent home. In Year 3, her sister started school and she had someone to play with and take care of. As a result, she settled down and attended school regularly. When Olivia was in her late teens her parents separated and she elected to stay with her mother while her siblings stayed with her father. Before the separation she had been close to her siblings but the separation, and subsequent divorce, had been acrimonious. She had sided with her mother and her siblings had sided with her father and that was the reason she saw her father and siblings infrequently now.

Recent history. At the time of interview, Olivia stated that she had found it difficult separating from Paul when he had left to live with his father. She missed him and would have preferred that he was living with her. She was still not sure that she had made the right decision in sending him to his fathers but she believed that having the company of his brothers was important as he found it difficult to make friends. He could "tag along with their friends and learn a few social skills." Mother admitted that she had felt under pressure from her partner to spend more time with him rather than with Paul (this had been another factor in her decision to send Paul to his father). The partner's business had also expanded. Mother worked longer hours and said that at times she was quite relieved not to have the responsibility of Paul. She felt guilty for feeling this way but was sure that the present situation "is best for everyone, especially Paul."

Parenting style. Olivia described her mother as being an anxious and overprotective woman who did not encourage her or her siblings to make friends, they played together at home and participated in family activities at the weekends. Olivia realised now that her mother did not appear to have

any friends herself and she probably kept her children close to her for company. She was not very strict but smacked Olivia and her siblings frequently for little things (i.e., for not eating all of their vegetables at tea time). Olivia had always made sure that she talked to Paul and explained what he had done wrong before she smacked him. Apart from that, her parenting style was similar to her mothers. She had not really encouraged Paul to participate in a sport, or join a club, where he could widen his circle of friends but tended to keep him with her. Olivia's partner had rarely shared in the parenting of Paul. He did not have children of his own and was both unsure of, and disinterested in, taking on a paternal role. The partner felt that Paul was Olivia's responsibility.

In summary, Paul (like Daniel) had been demanding of mother's time and attention when he was young. He had also been cautious with family members and family friends. He had difficulty settling at bedtime as a baby and as a toddler and woke at least once during the night and had to be comforted by mother. He had always found it difficult to separate from mother (i.e., as a baby, a toddler, at preschool, beginning Year 1) and was still concerned when separating from her.

Study 3: Darren

Darren lived in an inner Brisbane suburb with his mother and younger sister. The mother and father had divorced when Darren was 8 years of age and his sister was 6. The father had remarried and lived in the next suburb, although Darren and his sister seldom saw him because of the ill feeling between his natural parents.

Early history. As a baby, Darren suffered from colic. He was unsettled and restless at night when he had an attack of colic and would cough, then vomit. He had to be admitted to hospital on three occasions. When he was approximately 6 months old, the colic eased but he still woke during the night. Mother would give him a pacifier and if he was particularly upset, take him into her bed until he was settled. She would then put him back in his cot in his own room. Darren was also unsettled during the day. His eating patterns were regular, however, he was easily distracted when eating and would look at everything that was happening around him. He also had a poor appetite and mother found meal times quite frustrating and time consuming. He was hesitant with family members and familiar people and would cry if they approached him as soon as they came into the room, he appeared to need time to become accustomed to people. When approached by strangers he would stop playing and vocalising but would resume after a while. He stayed close to mother and would become upset when she was out of his sight (even when she went briefly to another room). Mother never left Darren with anyone other than her parents who lived in the same suburb. Even when left with the grandparents, who he saw at least twice a week, he would cry for a few minutes and take time to settle.

As a toddler, Darren developed asthma. He would be very unsettled at night when he had an asthma attack and mother would have to give him a nebuliser to help his breathing. He continued to wake in the night, however, when he was in good health and mother had to settle him by talking to him and stroking his forehead. He wanted mother's attention all through the day and became upset when she was out of his sight, he followed her everywhere he could. He was still hesitant with family friends and still took time to approach unfamiliar adults and children. He continued to be upset

when left with his grandparents and did not settle until mother returned.

School refusal history. Darren was 10 years old and in Year 4 when he was referred to CFTU by his local CYMHS clinic with separation anxiety/ school refusal. Mother had sought help from the clinic after he had contracted a virus then been unable to return to the classroom. Even though he had been cleared medically by the family doctor, he still complained of feeling ill. His school attendance had not been regular, however, for the two years since his parent's divorce. He had not attended preschool because he had become extremely upset when mother had tried to separate from him. When he started school, he cried each morning when mother tried to leave. The teacher would coax him to join activities to take his mind off mother going. By the end of the first term he had settled into class but he remained hesitant about going to school for all of Year 1 and for each successive year of his school life.

Darren was repeating Year 4 when he started school refusing. His teachers considered that he needed to repeat because he was immature, was not achieving academically, had low self-esteem, and relied heavily on his peers for support both academically and socially. When they suggested to the parents that he repeat, father agreed. Mother opposed the idea, but finally agreed. After the divorce, mother had gone against everything that Father had suggested about Darren's schooling. She believed that Darren's problems could be related to the divorce and wanted him to have minimal contact with the father.

Mother described Darren as "a changed boy the second time round in Year 4. He made friends and was more confident and mature." After contracting the virus, however, he had adopted a sick role and mother had

accepted his sick role behaviour. She was at school every day as Tuck Shop Convenor and reported that "Darren saw me as being on call for him whenever he felt sick." He had gone to school each morning for six weeks but left the classroom virtually as soon as he had arrived to go to mother in the tuck shop. Darren was admitted to CFTU for six weeks (two months prior to the Christmas school holidays) and re-admitted again to CFTU for four weeks (three days before the Christmas holidays ended). During his first admission to CFTU, Darren attended the hospital school for three weeks and was re-integrated to his home school over a three week period. During his second admission to CFTU his school re-integration commenced on the first day of the school year.

Darren attended daily sessions with his therapist (a social worker) and discussed with her the problems he was having separating from mother to attend school. He needed a great deal of support from the therapist, nursing staff, and hospital school liaison staff during both re-integration periods. The re-integration program for his first admission was as follows:

Week 1: Darren to school with liaison teacher or CFTU staff (support staff). Support staff sat at back of class for first three days, returned Darren to CFTU at 3pm.

To school, support staff in class till lunch time (two days) in staffroom till 3pm, back to CFTU.

Week 2: Darren and support staff to school, support staff in staffroom till 12 noon first three days. Darren picked up at 3pm by CFTU staff - back to CFTU.

Darren to school with support staff, support staff in staffroom till 10:30 (two days). Picked up at 3pm by CFTU staff - back to CFTU.

Week 3: Darren and support staff to school, Darren walked to class by

support staff for first two days. Third day, Darren dropped at school gate, walked to class alone. To CFTU at 3pm with mother. Darren, mother, support staff to school for next two days. Support staff modelled for mother dropping Darren at school gate, and saying goodbye while staying in car.

Darren went home for the weekend and mother took him to school on the following Monday. He was discharged from CFTU on the Monday afternoon. His second school re-integration, after the Christmas school holidays, was very similar to the first except that it was three weeks before Darren could overcome his anxiety and attend the classroom without support staff staying in the school for part of each day. During both re-integration periods he ran home from school, twice when support staff were in the school and twice after they had withdrawn. He was returned to school as soon as possible by his mother or support staff. Darren was re-admitted to CFTU for continuing problems with separation anxiety/school refusal on four more occasions while he was attending primary school. On each occasion he was re-integrated to his home school over 3 or 4 days from CFTU. Darren continued to see his therapist fortnightly while he was at primary school for help in overcoming his separation anxiety/school refusal. During his first year of high school he saw his therapist each week because his separation anxiety/school refusal had become more severe.

Present school functioning. Darren is 17 years old and no longer attends school. He had found it extremely difficult to attend school in Year 8 but had wanted to complete Year 10 so that he could commence a TAFE course. He began Distance Education at the beginning of Year 10 and attended the hospital school for the entire year. He attended regular

therapy sessions at CFTU during his lunch times and after school. While at the hospital school he was cautious in his interactions with school staff and had quite a degree of difficulty interacting with his peers. He was quiet and withdrawn, lacked self-confidence, and was anxious about his academic performance. He had isolated himself, or retreated, from unfamiliar adults and peers. His attendance was regular and he received his Year 10 certificate which enabled him to apply for the TAFE course of his choice. He found it impossible to attend TAFE the following year because he began to experience panic attacks when attempting to leave home.

Present home and social functioning. Until he was 12 years old, Darren had slept on a mattress on the floor of mother's bedroom. Now he slept through the night in his own bedroom. He still took time to interact with familiar adults and children, was never at ease in unfamiliar situations, and preferred not to interact with strangers. He stayed at home and made no effort to join clubs or activities where he could meet other teenagers. While he was attending the hospital school he had worked part-time at a fast food outlet but mother reported that "in the past year, he had become even more withdrawn, had lost any confidence that he may have had, had given up his job, and lost all contact with his friends." Mother described Darren as an extremely cautious boy who was still concerned at times when separated from her and still concerned when he was at home by himself. She doubted that he would ever be able to get a job because he was frightened to be away from the family home and was very dependent on her and his sister for support.

Study 3: Darren's Mother, Mary

Mary lived in the same suburb as her parents and saw them at least twice a week. Her older brother lived in Victoria. They saw each other once a year when he came to Brisbane to visit the parents, however, they kept in touch regularly by telephone or letter. Mary had not worked since Darren was born.

Early history. Mary had found it difficult to separate from her own mother when she was young. She could remember wanting to stay at home with her instead of going to school. In Year 1 she ran from the classroom and back to mother almost every morning for the first few weeks of the school year. She did settle, however, because her father began to take her to school - he was strict and Mary was always a little frightened of him. Throughout her school life, Mary's school attendance was regular although she never found it easy to go back to school after the holidays (especially the long Christmas breaks). She had always thought that she was anxious because she had attended numerous schools and found it difficult "to start over again. I had to make new friends again and again and I often felt that I never really belonged." Mary's father was in the army and the family moved regularly. Mary was not certain now, however, that this was the reason for her own anxiety because Darren's school problems were more severe than hers had been and his schooling had been very stable. Mary described herself as cautious, anxious, and lacking in self-confidence as a child. She rarely spoke in front of peers or adults and never asserted herself in group situations. She only had a few friends because she found it difficult "to break into groups that had been established for ages before I came to the school."

Recent history. Mary reported that she had found it very difficult to separate from Darren when he was young. In fact, she had found it so difficult to separate from him when he was to attend preschool, and both she and Darren had become so upset, that she had decided not to send him. She still found it concerning separating from him now. She was frequently anxious about his future and often wondered whether he would be able to get a job, be self sufficient, and cope without her later in life. She realised that she was very protective and was trying to encourage independence in Darren now but may have left it too late. She admitted that she depended on him for company and support because she had few friends and was "by nature" quiet, cautious, and lacking in self-confidence.

Parenting style. Mary was not as strict with Darren as her own mother had been with her. She described her father as being "heavy on discipline because he was in the army and he expected Mum to be strict too." Mary was still very close to her mother though, and they laughed together now about the way she had chastised her and her brother. Mary had always been responsible for Darren's parenting (i.e., discipline, going on outings, taking to school). Even before the divorce, the father had rarely been involved in the parenting role. His contact with Darren since the divorce had been minimal and Mary saw herself as both mother and father to Darren.

As with the boys in the previous case studies, Darren had found it difficult to separate from mother as a baby and as a toddler. He also had problems separating from mother when he was due to start preschool, in fact, he did not attend preschool because neither he nor mother could cope with being separated. He had taken time to settle in Year 1 and had remained hesitant about school all through his school life. After completing Year 10,

he had not been able to continue with his education or part-time work, had isolated himself from his peers, and had begun to experience panic attacks when attempting to leave home.

Study 4: Leon

Leon was an only child who lived with his mother and father in a small country town north of Brisbane. His maternal grandmother, uncle, and aunt lived in the same town.

Early history. In Leon's first 12 months of life, he suffered from ear and chest infections. Mother found it difficult to settle him at night. She would sing to him and give him a pacifier or a bottle of formula. If he still did not go to sleep, she would wheel him up and down the hall in his pram. He was always a restless sleeper and was hard to comfort when he woke. During the day he was unsettled, was a fitful sleeper, and his sleep patterns were irregular. His eating patterns, however, were regular. He was not easily distracted when eating, and was quite adventurous when given different foods. He was reasonably outgoing with family members when mother or father were present but would cling to mother and turn his head away when approached by someone strange. He was unhappy when he and mother were separated and would cry for up to an hour on the odd occasion that she left him. He was never left with anyone other than mother's immediate family.

Leon continued to have health problems (i.e., ear and chest infections) as a toddler. Mother reported that she babied him because of his illnesses and because he was the only child. He stayed close to her during the day and needed constant attention. Mother thought that this was the

result of having no one else to play with and only her for company. He had regular afternoon sleeps but was a poor sleeper at night and did not sleep in his own bed until he was 3 years 6 months of age. When he was teething, he woke 5-to-6 times a night. He was still wary of unfamiliar adults and children, and stayed close to mother in strange surroundings. He continued to cry and fret when he was left with his grandmother or other family members.

School refusal history. Leon was referred to Caboolture CYMHS by the school Guidance Officer when he was 11 years of age and in Year 7. He had attended preschool although mother admitted that she did not want to leave him there and missed having him at home. She had found it difficult to separate from him then and again when he started school. Leon's grandmother had been even more upset. Mother described her as being "devastated when Leon started school because she wouldn't see as much of him." Leon also found separating from mother difficult and would try to follow her. He had often needed to be held by the preschool teacher, and the following year, by the Year 1 teacher to prevent him from running after her. Mother had walked him to preschool each morning and had continued to walk him to school until he was 11 years old and in Year 7.

Leon's school attendance had never been regular. In Year 7 he began to miss 2-to-3 days of school a week so the school Guidance Officer was notified of his absences and a meeting was arranged with Leon's mother and father. A plan was formulated whereby the Guidance Officer, or class teacher, went to the home on the mornings that mother and father could not get Leon to school. This plan was unsuccessful because Leon refused to leave home and became increasingly upset at the prospect of separating from

mother. He was referred to the CYMHS clinic for more intensive therapy to address his separation anxiety/school refusal. Leon and mother were seen twice a week by the therapist (a registered nurse) assigned to their case. They discussed the possible reasons for Leon's separation anxiety/school refusal and both Leon and mother were given strategies to help ease their separation from each other. After two weeks of therapy, the following school re-integration program was devised:

Week 1: Leon and therapist walked to school each morning - mother stayed home. A school friend came to home and walked with them. Walked home by self or with friend at 3pm.

Week 2: Therapist to home. Leon and friend to school by selves. Home by self or with friend at 3pm.

Week 3: Leon to school by self or with friend. Home by self or with friend. Therapist rung if Leon refused to go to school - to come to home and take him to school.

The school re-integration program was very successful and Leon was attending school regularly at the time of the interview. A contract was devised by the therapist, presented to Leon and his mother, and agreed upon by both of them. The contract stated that if Leon began to miss school for other than legitimate reasons (i.e., sickness), he would be admitted to CFTU. Both Leon and his mother felt confident that he would not require follow-up therapy but they agreed to contact the therapist if problems arose.

Present school functioning. Leon is 11 years old and in Year 7. His teacher reported that Leon was cautious when interacting with him. He was also cautious in his peer interactions and had some difficulty initiating and

maintaining friendships. He retreated from unfamiliar adults and peers and took time to be at ease in new situations. He would not attempt any risk-taking activities (i.e., work tasks in the classroom, games in the playground). He was an anxious boy compared to his peers, lacked self-confidence, rarely asserted himself in group situations, and frequently relied on both adult and peer support in both social and academic situations. He often complained of headaches and stomachaches - mother was notified, however, she did not come and take him home as she did before the school re-integration program was implemented.

Leon had found it difficult to settle into school at the beginning of the year. He had come each day with mother but was concerned when she left. On occasions he would refuse to stay and would follow her home. Even now, after his re-integration, when he was attending school regularly mother would sometimes walk with him in the morning. He was still concerned when she left but would settle into class once he became involved in an activity.

Present home and social functioning. Leon was still prone to chest and ear infections. He did not settle at bedtime until father read with him and he (Leon) and mother had a chat. Mother called the chats "our special time together." He still woke 2-to-3 times a week and went into his parent's bedroom. If he was feeling unwell he would be allowed to sleep in their bed, otherwise he was encouraged to go back to his room. Mother described Leon as a quiet thoughtful boy who enjoyed being at home with her. He was not as outgoing with family friends as he was when he was younger and was cautious and ill at ease with strangers. He was hesitant with friends and preferred that they came to his home to play, or stay overnight, rather than he went to their homes. Leon's therapist had suggested to mother that she

should encourage him to be more independent and to go out with his friends. Mother admitted that she was finding this difficult as she and Leon had "always been so close and done so much together" and both of them still found it difficult to separate. She was complying with the therapist's suggestion and at the time of the interview Leon had slept overnight at a friends. He had also attended his first school camp, he had always been hesitant in unfamiliar situations and become too upset at the prospect of being separated from mother to attend a camp before.

Study 4: Leon's Mother, Wendy

Wendy had lived in the same country town for most of her life. She worked in Brisbane for five years after leaving school, then married and returned to her home town to live. She was the middle child in the family - her brother was six years older, and her sister 14 years younger, than her. Her mother was living in same town and she saw her at least three times a week (her father was deceased). Her siblings and their families also lived in the same town and she saw them once a week. She had not worked since before Leon was born.

Early history. During her childhood, Wendy suffered from asthma. She was hospitalised for treatment of her asthma at least twice a year until she was 12 years old. She was often absent from school because of asthma attacks but also "played on my sickness to get out of school. I was never very happy there." Her mother let her stay home if she complained of feeling sick or of having a tight chest (a warning sign of asthma). She did not like leaving her mother but while she had the support of her brother at school, she was able to separate from her and her school attendance was regular.

Her brother went to high school when she was in Year 3 and, from then until she left school at 15 years of age, she found school hard to cope with and her attendance was irregular. Although asthma was the cause of many of her absences, Wendy admitted that she had low self-esteem and was "totally lacking in self-confidence" (she remembers sitting under her brother's desk for the whole of her first day of school). She was terrified of strangers and was very shy, even with people she knew really well. When she was 16 years old she went to Brisbane to live with her grandmother. She went to work in a large department store and became more independent although she still did not consider herself to be an independent or confident person.

Recent history. Wendy was rarely separated from Leon when he was a baby. She found it difficult to separate from him then and still became concerned about separating from him now that he was 11 years old. She realised that she had to encourage him to become more independent, to make friends, and to join activities. She also realised that she had to become more independent herself and widen her interests because, in time, Leon would leave home and she would be "very lonely and my days very empty." She described herself as "reliant on my family, lacking self-confidence, depressed and nervous." She had recently been to her family doctor and was now taking anti-depressant medication.

Parenting style. Wendy reported that she had a very close relationship with her own mother. Her parenting style, however, was quite different to hers. Her mother had not been openly affectionate towards her and she had also been very strict: "children should be seen and not heard." She and her siblings were never allowed to join into any conversation their

parents were having, they had to be quiet when friends or family visited, and were never asked to express an opinion. Wendy had encouraged Leon to express his own opinions from the time that he was able to hold a conversation with her. She believed that they had a more open relationship than she had with her mother as a child. She could never discuss anything of importance with her mother, particularly things of a personal nature. She expected good behaviour from Leon (i.e., no butting into conversations) but was more casual and expressed affection more readily than her mother. Both she and her husband were very involved in parenting Leon.

Leon displayed many of the features displayed by the other boys (i.e., hesitancy with strangers, difficulty separating from mother, difficulty settling into school). He was cautious with his peers at school, found it difficult to initiate and maintain friendships, was anxious, and lacked self-confidence. Outside of school, he was also hesitant with peers and preferred them to come to his home rather than he go to theirs.

Study 5: Nathan

Nathan lived in an outer Brisbane suburb with his mother, sister, and maternal grandmother. He was the youngest of three children. His brother (who no longer lived in the family home) was six years older than he was and his sister was five years older. The mother and father had divorced when Nathan was 10 years old. Nathan had only seen his father twice since the divorce even though the father lived in a nearby suburb. Maternal grandmother had lived with the family for the past 22 years.

Early history. As a baby, Nathan had some health problems. He suffered from reflux (without vomiting) which was misdiagnosed by the

family doctor as asthma. He was initially treated for asthma then prescribed medication for reflux after mother had taken him to a paediatrician. His health improved once his medication was amended. Mother reported that he was contented during the day but "clingy and difficult to get to sleep." He was restless during the night and hard to comfort and get back to sleep when he woke. Mother would breast feed him, change his nappy, and rock him. If he still did not go to sleep she would take him into bed with her and father. His eating patterns were regular although he was distractable when eating. Mother described him as an alert baby who always wanted to know what was happening around him. He was outgoing with family members and friends but hesitant with strangers and in unfamiliar settings. He was unhappy when mother had to leave him and cried for about 10 minutes after she had gone. Mother rarely left him, however, and then only with grandmother.

Nathan was not talking by the time he was 18 months old. Mother took him to a paediatrician who found that he was quite deaf. He was admitted to hospital and had grommets inserted in his ears. After the operation he went to a speech therapist and began to acquire language rapidly. He was still contented during the day but continued to wake during the night. If he did not go to sleep after mother had comforted and talked to him, she would take him into her bed. By the time he was 4 years old he was no longer waking and was sleeping in his own room. He was outgoing with people he knew but still took time to approach unfamiliar adults and children. He separated more readily from mother but clung to a favourite soft toy and looked unhappy until she returned.

School refusal history. Nathan presented at CFTU when he was 11 years old and in Year 6. Mother had sought help from a psychiatrist who had, in turn, referred Nathan to CFTU for In-Patient treatment because of the severity of his problems. He had a long history of chronic separation anxiety/school refusal and some phobias (i.e., fear of showering and toileting - mother had to accompany him into the bathroom and toilet). Mother had tried to take him to preschool but he had refused to stay. He had screamed and clung to her when she attempted to leave. When the preschool teacher had tried to take him away from mother he had kicked and bitten her. After three weeks, mother decided not to persist with getting him to preschool as neither she nor Nathan could cope with separation.

At the beginning of Year 1, Nathan again found it extremely difficult to separate from mother. He settled after 3 or 4 weeks with the help of his older sister who stayed in his class until he could be engaged in class activities. He missed, on average, 1-to-2 days of school a week in Years 1 and 2. When the sister went to high school at the beginning of Nathan's Year 3 year and he no longer had her support, his attendance became more erratic. He would miss 2-to-3 weeks at a time. Mother would inform the school that Nathan was sick although a doctor's certificate was never tendered. In the last semester of Year 5, Nathan was absent for 13 of the 22 weeks and did not attend school at all in the first semester of Year 6.

Nathan was an In-patient at CFTU for six weeks. He attended the hospital school reluctantly for three weeks. He had to be assisted into the classroom on several mornings by CFTU staff and on occasions ran from the class only to be returned by CFTU staff. He found it very difficult to settle to tasks and was loud in his interactions with peers and teachers. The teachers thought that he could have been covering his nervousness and lack

of academic ability with this behaviour. In Year 5, he had been tested by the Guidance Officer at his home school and found to be in the average-to-high range of academic ability although his attainment was not commensurate with the test results (probably because of his frequent school absences).

Nathan was resistant to daily sessions with his therapist (a psychologist) for the first two weeks of his admission. He found it extremely upsetting being separated from mother but desperately wanted to go home and so agreed to work on his problems. Mother attended separate sessions with the therapist to work on her separation anxiety problems. Nathan was re-integrated to his home school after being an In-Patient at CFTU for three weeks. In the week prior to his re-integration, Nathan, his therapist, and the liaison teacher visited Nathan's school to meet with the principal, class room teacher, and learning support teacher. This was followed by a visit to Nathan's class. His re-integration took place over three weeks:

Week 1: Days 1 and 2 - Nathan to school with liaison teacher and CFTU staff (two support staff). Support staff stayed outside class for day. Returned Nathan to CFTU at 3pm.

Days 3 and 4 - Nathan to school with one support staff. Support staff outside class for day, returned Nathan to CFTU at 3pm.

Day 5 - To school with one support staff. Support staff outside class until 1:30 (after lunch break). Nathan picked up at 3pm by CFTU staff - back to CFTU.

Week 2: Day 1 - Nathan to school with one support staff. Staff outside class until 12:30. Nathan picked up each afternoon of week at 3pm by CFTU staff - back to CFTU.

Day 2 - Support staff stayed until 11:30.

Day 3 - Support staff stayed until 10:30.

Day 4 - Support staff stayed until 9:30.

Day 5 - Support staff walked Nathan to class.

Week 3: Days 1, 2 and 3 - Nathan dropped at gate by support staff, walked to class by self. Mother returned Nathan to CFTU at 3pm each afternoon of week.

Days 4 and 5 - Nathan to own home at 8:30. Mother took to school.

Nathan was discharged from CFTU at the end of his six week admission but re-admitted to CFTU on two occasions in Year 6 and three occasions in Year 7. The admissions ranged from three days to a week. Both Nathan and mother attended therapy sessions each week for help with their separation anxiety and Nathan for help with his continuing problems with phobias and school refusal.

Present school functioning. Nathan is 15 years of age and no longer attends school. He had not settled into high school at the beginning of Year 8 and had missed, on average, two days a week in the first term. His attendance was monitored by school staff and if he had not arrived in class and mother had not notified the school of the reason, CFTU was contacted. Nathan was admitted over night to CFTU on two occasions during the first term and returned to school by CFTU staff the following day. Mother found it increasingly difficult to get Nathan to school in the second term and failed to ring the school if he was absent. Both mother and Nathan were anxious about separating and mother admitted that she tended to give in to Nathan and let him stay at home. She thought it would be easier for both of them if he continued his education through Distance Education.

At the beginning of the second semester of Year 8 when Nathan had just turned 13 years old, he commenced Distance Education. He did not

submit assignments regularly and had effectively dropped out of formal education by the time he was 14 years of age.

Present home and social functioning. Mother reported that Nathan interacted readily with familiar adults and children if he liked them. If he did not like them, he would not even take time to speak to them. He preferred not to interact with strangers and was hesitant in unfamiliar situations unless he was with his current peer group. He was unconcerned when left at home during the day but was concerned when mother was away for the night even though the grandmother was always at home. Mother had only recently (i.e., in the past six months) begun to stay overnight with friends. Nathan would phone mother to make sure she was all right. He would also check to see that she was coming home at the time that she said she would. Mother believed that there was an element of control (as well as separation anxiety) in Nathan's concern for her. He was often out late at night with friends, participating in rather dangerous activities, without any apparent concern for her feelings on those occasions. He and his friends roamed the streets, experimented with drugs and alcohol, and disfigured buildings and fences with graffiti. They had not been in trouble with the police but "it could be just a matter of time," according to mother. Nothing she, or counsellors from her church said, had any affect on Nathan.

Study 5: Nathan's Mother, Fran

Fran was an only child brought up in a small town in West Queensland. She married when she was 19 years old "to escape from my mother" and came to live in Brisbane. Her mother came to live with her, however, just prior to the birth of her first child, Fran's father having died unexpectedly.

Early history. Fran described herself as a lonely unhappy child. She had very few friends at school and never brought friends home to play. She was often left by herself in the evenings because her mother was an alcoholic and either went to the hotel or to friends' houses. Her father was a heavy drinker who worked away from home for 3 out of every 4 weeks. She reported that she had no problems at all separating from her mother, in fact, she enjoyed going to school to get away from her. She felt that she was made fun of at school and teased at times because of her mother's haphazard parenting and unpredictable behaviour. She never let the other children see that she was upset but "deep down it hurt." She very rarely had a day off school because it was preferable to go to school than to stay at home.

Recent history. Fran reported that early in her marriage she had "found a refuge in the church." Although her mother was no longer an alcoholic, she had needed to be away from her because she was very critical of the way Fran managed the children. Her mother had thought that she was not strict enough and gave them too much (i.e., toys, clothes), particularly Nathan. Fran had become more heavily involved in the church since her marriage break-upand she relied on the church for support when she was having difficult times with Nathan. Fran admitted that her family was very enmeshed and she was overprotective but she believed that "its probably because of my own up-bringing. I didn't have any family life and I've worked hard to make sure my children have everything that I missed out on."

Parenting style. Fran described her parenting style as being very different to her mothers'. She felt that she was more understanding

and sympathetic. She certainly spent more time with her children and made sure they were never left alone in the house when they were young (as she had been). She involved herself in their activities and encouraged them to become involved in youth groups within the church. She described her relationship with her mother as "quite distant at times and quite close at times - a love-hate relationship really." Her mother had become more demanding of her time over the years, she rarely went out, and was dependent on Fran, Nathan, and his sister for all social interaction.

In summary, Nathan unlike Daniel, Paul, Darren, and Leon was settled and contented during the day and was outgoing with family members and friends both as a baby and a toddler. He could not attend preschool because of separation anxiety, had problems with school attendance from Year 1, and found the transition from primary school to high school difficult. He commenced Distance Education at 13 years of age but failed to continue past the age of 14 years.

Study 6: Eric

Eric lived in Brisbane with his mother and a brother eight years older than him. Another brother (11 years older) lived in Adelaide with the father. The parents had separated when Eric was 8 years old and mother and the two boys had moved interstate. Eric had not seen his father since moving to Brisbane but had regular telephone contact with him. The parents were originally from Germany and the family spoke German in the home.

Early history. Eric was born four weeks prematurely. Mother reported that she was nervous caring for him initially. She also felt that she had lost some of her confidence with young babies after an eight year gap between

Eric and his older brother "but lucky for me, Eric was always healthy and happy." He was contented during the day and only woke during the night when he was teething. At other times, he was restful at night and his sleep patterns were regular. His eating patterns were not particularly regular. He was fussy when it came to trying new foods and was distractable when eating. Mother fed Eric whenever he seemed to be hungry which made it difficult to get him into a routine during the day. Mother found that this made her anxious about the way she was managing the household and she was often stressed. Eric was cautious with family friends (neither mother nor father had family in Australia). He stopped playing and vocalising when anyone strange approached and took time to resume again. He was hesitant in unfamiliar settings and clung to mother "like a limpet." He cried when mother left him with babysitters and was unhappy until she returned. The mother left him very rarely preferring to go out only when father could babysit.

When Eric was 2 years old, father became unemployed and mother went to work full-time (father stayed home to run the house). Father was more of a disciplinarian than mother and more rigid about meal times. Eric settled into a set daily routine. He played contentedly when awake and slept through the night. He was still cautious with family friends, played quite close to mother in new situations, and wanted to be cuddled or nursed by her when approached by strangers. He still became upset when left with father or babysitters and remained unsettled until his mother's return.

School refusal history. Eric was referred to CFTU by his local CYMHS clinic when he was 9 years old and in Year 4. Mother had sought help from the clinic soon after arriving in Brisbane because Eric was having difficulty

attending school. In Adelaide, he had missed on average one day a week of school; in Brisbane he was missing on average 2-to-3 days a week. Some days he would arrive at school only to run home to mother when the teacher was busy with other children. Eric had settled into preschool and school easily and had only begun to manifest signs of separation anxiety/school refusal when he was 7 years old. This was around the time that mother gave up work because father had regained full-time employment. Her giving up work also coincided with problems in the marriage. Eric found it difficult to separate from mother and worried about her while he was at school.

Eric was admitted to CFTU for five weeks. He was resistant to attending daily sessions with his therapist (a social worker) and would answer the therapist, or make comments, in German. When he and mother attended joint therapy sessions, or when mother visited, he would only speak in German. At the end of each visit, he would cling to mother, cry, and plead with her to take him home. He would also attempt to follow her and would have to be restrained by CFTU staff until she had gone.

Eric attended the hospital school for three weeks. On the first three days, he needed help to settle into the classroom and a CFTU staff member had stayed with him until his anxiety abated. Once he had settled into the class routine, he was quiet and cooperative. He was above average in all areas of the curriculum. He had a sound grasp of basic maths concepts and well developed language skills. He was re-integrated to his home school, at the end of three weeks, when he was able to separate from mother appropriately (i.e., without crying, clinging to her, following her). His re-integration took place over two weeks and was as follows:

Week 1: Day 1 - Eric to school with liaison teacher and CFTU staff member (support staff). Eric in class, support staff outside class till 1:30.

Eric picked up at 3pm each day of week by CFTU staff - back to CFTU.

Days 2 and 3 - Eric to school with one support staff, support staff outside class till 10:30.

Days 4 and 5 - Eric to school with one support staff, support staff in staffroom till 9:30.

Week 2: Day 1 - Eric walked to class by support staff. Support staff in staffroom till 9:30. To CFTU each afternoon with mother.

Days 2 and 3 - Eric dropped at gate by support staff, walked to class by self.

Day 4 - Eric, mother, support staff to school. Support staff modelled for mother dropping Eric at school gate, saying goodbye while remaining in car.

Day 5 - Support staff and Eric to home, mother took Eric to school.

Eric went to school with mother (from home) on the following Monday. He was discharged from CFTU but continued to see his therapist every fortnight until the end of Year 4, then every month in Years 5 and 6. He was re-admitted to CFTU on two more occasions in Year 4, three occasions in Year 5, and two occasions in Year 6. He was re-integrated to his home school over 2 or 3 days and put on a contract after each re-integration. His contract stated that if he failed to attend school (for reasons other than sickness) he would be re-admitted to CFTU for a longer period.

Present school functioning. Eric is 12 years old and in Year 7. There had been no problems with his attendance so far in the current year. He appeared to have gained in confidence since the beginning of the year but was still hesitant at times with children in his class and the class teacher. He

remained hesitant with peers and adults he was not familiar with. He was reserved when participating in group activities and discussions but had not displayed any overt signs of anxiety. The teacher described Eric as a friendly, polite, cooperative boy who had settled into the class routine extremely well.

Present home and social functioning. Eric had started coming into mother's bed, and sleeping with her, soon after the family's move to Brisbane. He had continued to sleep with her on occasions (i.e., when he was having difficulties going to school) until he was 11 years old. He was now sleeping through the night in his own bed and, recently (in the past month), stayed overnight with a school friend for the first time since living in Brisbane. He was interacting readily with family friends but was hesitant at times with certain peers outside of school (i.e., members of his soccer team). He was still cautious with strangers and took time to be at ease in unfamiliar situations. He still became concerned when separated from mother; she did not like leaving him unless she had to. Mother described Eric as talkative, outgoing, and confident at home but cautious, quiet, and lacking in self-confidence when out in public or away from her. She found that he was jealous of any of her male friends so she was trying to make him more independent of her as she was anxious to have a life of her own. Mother had always taken Eric to soccer matches in the past and stayed to watch because he had insisted that she do so, but now he was going to matches with a team member.

Study 6: Eric's Mother, Claudine

Claudine was brought up in Germany and came to Australia when she was newly married. She had not seen her parents and younger sister since leaving Germany but was in contact with them regularly. She had no other family in Australia although there was a small group of German people at the church she attended who gave her a great deal of support.

Early history. Claudine described her childhood as "fairly average. I did all the usual things children do - played with friends, visited my grandparents, went on holidays, played sport, went to the movies." She reported that she liked school and settled into each new class quite easily. Her attendance was regular and she was only absent because of the normal childhood illnesses. She was fairly quiet and timid and did not assert herself in groups and "looking back, I guess I didn't make friends easily." Claudine had a large extended family who saw each other frequently and so she always had cousins to play with. She usually separated quite easily from her mother and could not recall ever clinging to her mother like Eric used to cling to her.

Recent history. Although Claudine had been able to separate easily from her two older boys when they were young, she had found it difficult to separate from Eric. He would become upset and cry which, in turn, would upset her. When she was working full-time and father cared for Eric during the day, she had found it easier to separate because she always seemed to be in a rush to leave for work. She reported, "I couldn't let myself get upset and arrive late for work. I needed the job with three boys and a husband to look after." When Eric began school refusing after the move to Brisbane,

Claudine found herself becoming anxious and upset again when separating from him. She was not quite as anxious now that he had settled into school but she admitted that there was still some anxiety there. She was also protective of him, probably because he was four week's premature and was the youngest of her children by quite a number of years.

Parenting style. As primary caregiver while mother was at work, father was highly involved in Eric's parenting although he rarely became involved in any extra duties (i.e., taking to sports fixtures, going on weekend outings, taking for a hair cut). Eric's older brother had assumed some of the parenting role since the move to Brisbane but the responsibility was still largely mothers'. She described her parenting style as being similar to own mothers'. She was stricter than her own mother though, because her mother had left the discipline to her father. She had threatened Claudine and her sister with "you wait till your father comes home. He'll deal with you." Claudine handled discipline herself and at the time that something happened that needed dealing with. Her relationship with her mother was still close even though they had not seen each other for 24 years. They wrote to each other regularly and rang each other on special occasions (i.e., Christmas, birthdays, Mother's Day).

In summary, three of the mothers (Olivia, Mary, and Claudine) had similar parenting styles to their mothers'. The other three (Teresa, Wendy and Fran) had different parenting styles to their mothers' and all had made a conscious effort to parent differently (i.e., stay home and spend time with children, show more affection, never leave children alone in the house). Teresa, Olivia, and Claudine described themselves as protective of their children/adolescents, while Mary and Fran described themselves as

overprotective, and Wendy did not encourage independence in her child. The mothers' parenting styles appeared to have affected both themselves and their children/adolescents in that both mothers and children/adolescents were still concerned and anxious about separating from each other.

The situations reported in the six case studies appear to be typical of situations reported in the literature, namely that children with school refusal:

* have difficulty separating from their mothers;
* are timid and withdrawn away from the home setting;
* display severe emotional upset when faced with going to school;

Mothers of school refusal children:

* are anxious, overprotective, and do not encourage independence in their children; and
* their anxiety increases their children's risk for separation anxiety/school refusal.

Comparison of Former School Refusal Children/Adolescents

Of the six children/adolescents reviewed in the current study, three lived in Brisbane and two lived in country towns outside of Brisbane at the time of their presentation with separation anxiety/school refusal. One boy lived in New South Wales but moved to Brisbane soon after presentation. Two children/adolescents were from intact families, three lived in a single parent household, and one lived in a blended family. Their characteristics are presented in Appendix H.

The characteristics of school refusal children/adolescents were reported in Chapter 3. School refusal occurs in children/adolescents:

* of varying intellectual ability;
* from small to average size families;
* between the ages of 5-7, 11-12, and 13-14 years (major peak 11-12 years); and
* both male and female children/adolescents are affected equally (Hersov, 1985b; King, Ollendick, et al., 1998; Ollendick & King, 1990; Paige, 1993; Thyer & Sowers-Hoag, 1986).

Similarities and differences between the six former school refusal children/adolescents were found in all of the areas mentioned immediately above and also in the areas of their early history (Appendix I), school refusal history and present school functioning (Appendix J), and home and social functioning (Appendix K).

Mothers of Former School Refusal Children/Adolescents

Of the six mothers of former school refusal children/adolescents, all reported that they had been anxious during their own school days, had few friends, and/or had difficulty making friends. Four mothers had irregular school attendance or had difficulty settling into school. At the present time, they were all anxious about their former school refusal child/adolescent. Their school histories and recent histories are presented in Appendix L.

Discussion

Data from the current study suggests that former school refusal children/adolescents:

* as babies and toddlers were hesitant with strangers and unhappy when left with grandparents or babysitters;
* manifested signs of behavioural inhibition before they manifested

separation anxiety;

* remained stable in their behaviours as a baby, toddler, and at 5-to-6 years old;
* were anxious at school and their attendance was irregular prior to presenting at a CYMHS clinic with separation anxiety/school refusal;
* if still attending school remained hesitant with peers and teachers; and
* at present, were hesitant with strangers and in unfamiliar situations, and concerned when separated from mothers.

Mothers in the current study were expected to rate their children/adolescents as babies, toddlers, and at 5-to-6 years old as having been positive in mood, rhythmic, and at ease with family and familiar people. All mothers rated their children/adolescents, however, as displaying some (or all) of the behaviours that indicated that they were negative in mood and arrhythmic. Of the six children/adolescents, all but one were cautious with family and familiar people; all six were hesitant with strangers and unhappy when left with grandparents or babysitters. All six children/adolescents, therefore, would appear to have been difficult babies who manifested major signs of behavioural inhibition as toddlers and at 5-to-6 years. Their behaviours remained stable across the time periods.

Researchers have suggested that difficult babies have a temperamental quality that predisposes them to behavioural inhibition followed by separation anxiety (Biederman & Rosenbaum, 1994; Deltito & Hahn, 1993; Schreier, 1992). Separation anxiety is characterised by excessive anxiety, distress, and fearfulness on separation from major attachment figures, particularly mothers, (Doll, 1987; Ollendick et al., 1993; Wachtel & Strauss, 1995). Children/adolescents in the current study

displayed all of the behaviours mentioned immediately above plus refusal to attend school. Prior to their presentation at a CYMHS clinic with school refusal their school attendance had been irregular. Only one child/ adolescent had been able to separate easily from the mother at both preschool and in Year 1 (the first year of primary school). Of the three children/adolescents still attending school, all were hesitant with teachers and peers. The inability to form and maintain satisfying peer relationships is an outcome of school refusal behaviour as is delayed learning and/or academic deterioration, a lack of independence, and school conflicts (Blagg, 1987; Heath, 1985; Paige, 1993; Strzelecki, 1984).

At the time of the interviews with the mothers, all of the children/ adolescents remained hesitant and/or cautious with strangers and in unfamiliar situations: all children/adolescents were still concerned when separating from mothers while all of the mothers were still concerned when separating from them. School refusal children remain in close contact with their mothers and are characteristically overdependent on them. Mothers of school refusal children are dependent on their children and have, in turn, unresolved dependent relationships with their own mothers (Atkinson et al., 1989; Kahn et al., 1981; Ollendick & Mayer, 1984).

Of the six mothers in the current study, two saw their own mothers frequently, two had regular contact with them (one mother lived interstate and one overseas), and two had their mothers living with them. Five mothers reported having "quite close to very close" relationships with their mothers while one reported having a "love-hate" relationship with her mother.

The following chapter will summarise the major issues arising from Studies 1, 2, and 3. Limitations of the studies will be presented. Finally, implications for the early identification of separation anxiety/school refusal will be discussed.

CHAPTER 7

DISCUSSION: REFUSAL TO ATTEND SCHOOL DUE TO SEPARATION ANXIETY AND/OR SCHOOL PHOBIA

Although school refusal only occurs in a small number of children, its effects can be far-reaching. The child's immediate family, extended family, and school are all often involved in the child's diagnosis, treatment, and subsequent education. This chapter will summarise the major issues arising from the three studies undertaken in this project, discuss a number of limitations of the studies, outline the implications for the early identification and treatment of school refusal, and suggest directions for further research.

Major Issues Concerning Children, Arising from Studies 1, 2, and 3

Studies conducted in the past into school refusal have dealt with: history, clinical presentation, theories of development, and classification of symptoms; identification, incidence, and outcomes; philosophies underlying different treatment methods, their success and/or failure; and differences between preadolescent and adolescent school refusers. In only three research programs have links been made between behavioural inhibition, separation anxiety, and school refusal followed by panic disorder with agoraphobia (Deltito & Hahn; Rosenbaum et al., 1988, 1989). Behavioural inhibition in relation to school refusal was not specifically discussed by these authors although there was an emphasis on behavioural inhibition as a precursor to separation anxiety and later anxiety disorders. The current studies have attempted to examine behavioural inhibition as a precursor to separation anxiety followed by school refusal.

Behavioural inhibition. Findings from Study 1 suggest that the percentage of behaviourally inhibited children in the general population is less than reported from laboratory studies. Mothers appear to perceive their children differently to clinicians observing children. Clinicians have typically looked for specific indicators of behavioural inhibition and by observing children for short intervals and in unnatural settings. Mothers see their children across different situations and settings. They have been accustomed to their children's behaviour from birth and, therefore, can average out their behaviours over time instead of focusing on specific aspects of it. Mothers in Studies 1 and 2 saw their children's behaviour in a positive light. A significant number of mothers of behaviourally inhibited children, however, have past histories of childhood anxiety (Rosenbaum, Biederman, Hirshfeld, Bolduc, & Chaloff, 1991). In comparing their children's behaviour to their own childhood behaviour they consider it to be normal and rate it accordingly.

Data reported in Studies 1 and 2 suggest that children's behaviour across time is generally not especially consistent. It is difficult, therefore, to predict children's future behaviour from their behaviour as a baby. Data from the sample in Study 1 indicated that behaviour can be predicted across three periods (from baby, to toddler, to 5-to-6 years) in two areas only (i.e., reaction to family/familiar people, reaction to unfamiliar settings). Data from Study 2 indicated that behaviour in uninhibited children can be predicted across three periods in one area only (i.e., reaction to family/familiar people). Behaviour in inhibited children can not be predicted across three periods in any area unless the children's behaviour is extreme.

The only extreme behaviours were reported by Study 3 mothers whose children/adolescents had been treated for separation anxiety and school

refusal. Even mothers of children identified in Study 2 as behaviourally inhibited rated their children positively on 10 of the 13 items related to their behaviour as a baby. Study 3 mothers rated their children/adolescents as displaying some (or all) of the behaviours that indicate that as babies they were negative in mood and arrhythmic and extremely inhibited as toddlers, preschoolers, and at school. Children who are extremely inhibited remain inhibited throughout childhood and have an increased risk for developing childhood anxiety disorders (Biederman et al., 1990, 1993; Hirshfeld et al., 1992).

Findings from Study 2 indicate that children identified as behaviourally inhibited remain inhibited after the transition from preschool to Year 1 (primary school). The majority of Group 1 children identified as behaviourally inhibited by preschool teachers were rated by Year 1 teachers as still being inhibited at the end of the first semester (six months after the commencement of Year 1) and still experiencing difficulties settling into school. Children's temperamental style has been reported as a significant factor in predicting school adjustment difficulties throughout the school years (Beeghly, 1986; Biederman et al., 1990; Rosenbaum et al., 1988). Behaviourally inhibited children are more likely to be fearful, quiet, and noninteractive with their peers on the first day of kindergarten/preschool and on follow-up six months later (Gersten, 1989; Hirshfeld et al., 1992).

Group 1 mothers rated their children differently to both the preschool and Year 1 teachers. Billman and McDevitt (1980) reported that agreement of temperament estimates at school and at home should be moderate to high, however, the environments are different so agreement is likely to vary. Group 1 mothers' ratings compared to preschool and Year 1 teachers' ratings varied considerably. Mothers rated only 10 of the 25 children as inhibited. It

could be that children are less inhibited in their normal home environment or mothers' memories may be biased and reflect their current ideals (Henry et al., 1994).

Separation anxiety and school refusal. Findings from Study 3 indicate that children who exhibit extreme behavioural inhibition are predisposed to separation anxiety followed by school refusal. All of the children/ adolescents in Study 3 exhibited extreme behavioural inhibition and all of them displayed signs of separation anxiety before they presented for treatment for their school refusal. Four of the children/adolescents were the youngest child in the family. Seventeen (68%) of Study 2 behaviourally inhibited children were the youngest or later born in the family which suggests another link between behavioural inhibition, separation anxiety, and school refusal. Researchers have reported that approximately two-thirds (66%) of behaviourally inhibited children are later born (Kagan et al., 1987, 1988; Reznick et al., 1989). There appears to be some disagreement about birth order of children with school refusal. A tendency for lateness in birth or significant numbers of youngest children, however, have been reported (Berg, 1991; Berg et al., 1972; Blagg, 1987; Hersov, 1960a, 1960b).

Characteristics of children with school refusal. Findings from Study 3 indicate that children with school refusal cannot be classified by the characteristics they display. Their gender, family size and/or make-up, and age on presentation for school refusal can vary. All children/adolescents in Study 3 were males. Family sizes were generally small to average: two children/adolescents came from intact families, three from single parent

families (i.e., parents divorced), and one from a blended family (i.e., parents with different partners). They presented with school refusal between the ages of 7-to-11 years and all were attending primary school on presentation. One child/adolescent presented with a neurotic disorder (i.e., a phobic reaction to showering, toileting). Separation anxiety preceded the school refusal in all six children/adolescents: five exhibited signs of separation anxiety at preschool when aged between 4 and 5 years.

Researchers have reported that three characteristics are common to children with school refusal: the incidence is equally distributed across the sexes; families are small-to-average size, united, cohesive, and intact; and children present between the ages of 5-to-7, 11-to-12, and 13-to-14, with the major peak at 11-to-12 years (Blagg, 1987; Blagg & Yule, 1984; Cooper, 1966b; Hersov, 1985b; Ollendick & King, 1990). Hersov (1985b) suggested that the prevalence of school refusal at 5-to-7 years is probably due to separation anxiety while at 11-to-12 and 13-to-14 years to a change of school or one of a variety of neurotic disorders. Researchers do not indicate whether the ages suggested immediately above denote when children actually present for treatment or when children first exhibit signs of school refusal.

All of the children/adolescents in Study 3 had difficulty attending school due to separation anxiety: five attended irregularly from Year 1 onwards and one from Year 3 onwards. The onset of their school refusal was gradual although they did not present for treatment until it became severe. Researchers have suggested that when children are younger than 11 years the onset of their school refusal is more sudden than if they are older than 11 years. Their symptoms are more acute and they are perceived as being less disturbed. They respond positively to treatment and are successful in

returning to school irrespective of the treatment approach (Berg, 1970, 1980b; Cooper, 1986; Leton, 1962; Paige, 1993; Trueman, 1984b).

Treatment issues. Of the six children/adolescents in Study 3, one was treated in the community and five were hospitalised. All were successfully returned to school, however, three of the children/adolescents admitted for hospital treatment found the transition from primary school to high school distressing and left school to continue their education by Distance Education.

School refusal that is severe and resistant to treatment by professionals in the community often requires intense concentrated hospital treatment. Researchers have indicated that 50-59% of hospital-treated school refusers are successfully returned to school, however, they experience difficulty relating to peers and teachers and are somewhat socially isolated (Borchardt et al., 1994; Radin, 1968; Weiss & Burke, 1970).

In summary, findings from the three studies indicate that:

* only those children exhibiting extreme behavioural inhibition are predisposed to separation anxiety followed by school refusal;
* school refusal children can not be classified solely by the characteristics they display;
* preadolescent school refusal children may not respond to treatment as positively as researchers report; and
* hospital treatment may not be as successful as has been reported by researchers.

Issues concerning mothers. Findings from Study 2 suggest that mothers of both behaviourally inhibited and uninhibited children were

positive about their own childhoods. Both groups of mothers generally found it difficult to separate from their children, were sometimes anxious about them, and were frequently protective of them. These reactions (i.e., separation, anxiety, protectiveness) are natural reactions particularly when children are young and still dependent on mothers. When these reactions are extreme, however, mothers stifle children's attempts to gain independence and confidence. Children fail to achieve separation individuation, remain emotionally dependent on mothers, and in later years are prone to developing anxiety disorders, in particular, separation anxiety (Goldenberg & Goldenberg, 1970; Gottschall, 1989; Hock & Schirtzinger, 1992; Hoffman, 1984).

Study 3 mothers reported having positive relationships with their own mothers (one reported a "love-hate" relationship). Two mothers had their mothers living in the family home. Two mothers lived in the same suburb or small country town as their mothers, and two had mothers who lived interstate or overseas - contact between these four mothers and their mothers was frequent. Only two of the six homes were intact and only two fathers involved themselves in the parenting role. Mothers remained anxious about their children/adolescents and still found it concerning when separating from them. They appeared to reinforce their children's/ adolescent's separation anxiety/school refusal because of their own anxiety.

Researchers have suggested that mothers of school refusal children are overprotective of them because they feel insecure about their competence as a mother. They have unresolved dependency needs, are often neurotically involved with their own mothers, and live in close proximity to them. Mothers foster over-dependency in their children and rely on them for emotional support because of marital disharmony. Fathers fail to play a

supportive role in the marriage or take on a responsible parenting role (Atkinson et al., 1985; Blagg, 1987; Heath, 1985; Hersov, 1985b; Kahn et al., 1981; Talbot, 1957).

Study 3 mothers were anxious at school and/or quiet, timid, and lacking in self-confidence. Group 1 (Study 2) mothers were also anxious at school but had no difficulty attending regularly. Two Study 3 mothers had no difficulty attending regularly but two had difficulty settling into school and two displayed quite extreme behaviours (i.e., would not stay at preschool, pretended to be sick, ran home from school) The latter two mothers did not compare their behaviour to their children's/adolescent's nor did they perceive themselves as having school refusal. Mothers of children with separation anxiety/school refusal, however, are more likely to have been anxious at school themselves and/or suffered from school refusal (Phelps et al., 1992).

In summary, mothers of the former school refusal children/adolescents exhibited more extreme behaviours (i.e., difficulty settling into school, concern about separating from their children/adolescents) than mothers of the children identified as behaviourally inhibited. It would appear that the more extreme that mothers' behaviours are, the more likelihood that their children will present with behavioural inhibition followed by separation anxiety and school refusal.

Limitations of the Studies

Two points have emerged from the studies. First, the difficulty in procuring sufficient participants for the studies, particularly for Studies 2 and 3. Second, the lack of recent literature on separation anxiety and school refusal.

Although every attempt was made to recruit mothers for Study 1 only about 50% of mothers responded to the questionnaire. As reported in Chapter 4, Year 1 teachers had difficulty getting mothers with whom they had no face-to-face contact to return the questionnaire. Mothers with whom the teachers had contact were more willing to participate as they were able to question teachers about the study. There were no issues about confidentiality as children's first names only were required on the questionnaire.

Preschool teachers in Study 2 encountered problems in identifying behaviourally inhibited children then recruiting their mothers. Given that the percentage of behavioural inhibition in the general population of young children is comparatively low (10-15%), a number of preschools had no children who fitted the criteria for behavioural inhibition. Some preschool teachers recommended to parents that their behaviourally inhibited children repeat preschool, some were already involved in other studies, and some were uncomfortable about approaching mothers after having identified children because of issues with confidentiality. As a result, the number of identified children was small and not all of the mothers approached by the preschool teachers agreed to participate in the study.

Confidentiality was a major issue in Study 3. The majority of therapists who treated children for school refusal at mental health facilities (i.e., Child and Youth Mental Health Service clinics) were hesitant to approach mothers. Those therapists who distributed questionnaires to mothers, asked the mothers to discuss the study with their children before signing the consent form. The ensuing response rate was low.

The researcher was unable to discuss the study with potential participants because participants may have perceived their identification

through the preschool or mental health clinic as a breach of confidentiality by the teacher or therapist. The response rate may have been higher had the researcher been able to explain the study and its purpose. It would appear that where confidentiality is involved, people are unwilling to give information about themselves or others, particularly if mental health is an issue.

As reported in Chapter 2, the number of articles on school refusal was high up until 1980. There were fewer numbers of articles published up until 1990 and only five published in 1998. It has been difficult, therefore, to compare the findings from Studies 1, 2, and 3 with the literature when the majority of articles are over 20 years old and clinicians' ideas on the various aspects of school refusal (i.e., theories of development, characteristics of children and mothers, treatment methods) may have changed. Notwithstanding the limitations of the studies, useful information has emerged which may assist in the early identification of separation anxiety/school refusal.

Implications for the Early Identification of Separation Anxiety/School Refusal

Researchers have suggested that behavioural inhibition can be identified in children much earlier than separation anxiety or anxiety disorders (Hirshfeld et al., 1992). It may be possible, therefore, to identify children at-risk for separation anxiety and school refusal when they are still at preschool, ease their transition to Year 1, and monitor their progress through the school years.

Although preschools provide children with experiences to ease their transition into (what may be for some) the stressful situation of Year 1,

researchers have suggested that planned separation from mothers for gradually increasing times should also be arranged (Ollendick & Mayer, 1984). They do not indicate who should be responsible for the planned separation but the planned separation could be particularly beneficial to behaviourally inhibited children.

The incidence of behavioural inhibition in the general population of children is reported to be 10-15% (Biederman et al., 1990; Reznick et al., 1986). The incidence of separation anxiety is 3.5-4% (Bernstein & Garfinkel, 1992; Perugi et al., 1988). The incidence of school refusal is estimated from 1.7% to as high as 5-8% (Doll, 1987; Kearney et al., 1995; Kearney & Silverman, 1993, 1995). The majority of behaviourally inhibited children, therefore, would not progress to separation anxiety and school refusal but an identification process in the preschool could be of benefit to their future teachers and alert them to the possibility of problems with school attendance.

Separation anxiety and/or school refusal begins with vague complaints about school followed by complete refusal to attend school. Children frequently fortify their protests about school (both at home and at school) with somatic complaints (Hersov, 1985b; Radin, 1967; Silber, 1982). Teachers need to watch for patterns of continuous absences, particularly in children who frequently request to go home because of illness and who appear to be anxious and/or depressed. Problems may arise if teachers do not refer these children immediately to the appropriate treatment agency as the delay in treatment decreases the likelihood of a successful return to school (Paige, 1993). Assessment of children's intellectual level and their academic achievement is also important. If children are experiencing difficulties attending school, then their anxiety about their academic

progress may exacerbate the problem of their poor school attendance (Hersov, 1985b).

When children begin to exhibit signs of separation anxiety and/or school refusal, it is important that an immediate diagnosis is made and a treatment plan organised and implemented as soon as possible. A coordinated team approach involving the class teacher and other significant school staff (i.e., Guidance Officer, Principal) should be used. Because of the low incidence of separation anxiety and school refusal, however, the experiential knowledge of many school personnel may not be sufficient to either identify or treat the problem: an immediate referral to an outside agency, therefore, should be made (Paige, 1993).

Directions for further Research

Researchers have suggested that difficult babies have a temperamental quality that predisposes them to behavioural inhibition, followed by anxiety (particularly separation anxiety), and possibly school refusal (Deltito & Hahn, 1993; Rosenbaum et al., 1988, 1989). This being so, it is surprising that no studies have specifically examined behavioural inhibition as a precursor to separation anxiety and school refusal. Longitudinal studies need to be undertaken that follow behaviourally inhibited and uninhibited children from preschool through to an age when separation anxiety and/or school refusal are most likely to occur (i.e., 5-7, 11-12, 13-14 years). Significantly higher numbers of behaviourally inhibited and uninhibited children would be required for future studies compared to numbers of children procured for Study 2. Reznick et al. (1989) reported that "researchers wishing to study inhibition in relatively small normative samples may fail to find statistically significant effects because they do not

have a sufficient number of inhibited and uninhibited children" (p. 47). This appears to be the case in Study 2 with 25 children in the inhibited group and 25 in the uninhibited group. Even though findings in Study 3 indicate that children who are extremely inhibited are predisposed to separation anxiety followed by school refusal, the sample (six children/ adolescents) was even smaller. Five of the six children/adolescents presented with severe school refusal that required hospitalisation and so they may not have been representative of a normal group of school refusal children.

The lower numbers of behaviourally inhibited children and the higher numbers of uninhibited children found in Study 1 compared to numbers of inhibited and uninhibited children found in laboratory studies (i.e., 10-15%) suggest another area for future research. If children are rated by mothers, or by researchers in more natural settings and more normal situations than laboratory settings/situations, the percentage of behavioural inhibition could be lower and the percentage of uninhibition be higher than researchers have reported.

Despite their limitations, the studies (in particular Study 3) suggest that behavioural inhibition that is consistent and extreme leads to separation anxiety followed by school refusal. If children are identified early and their progress monitored through preschool and primary school many of the problems associated with separation anxiety and school refusal may be alleviated.

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APPENDIX A

Questionnaire A

SCHONELL SPECIAL EDUCATION RESEARCH CENTRE

Study of children's reactions to school

Preschool:..... Location:.....

Part A Date:../../..

Please list (in the spaces at the bottom of the page) any children who:

* currently attend your preschool;
* are in their last term of preschool; and
* when compared with peers of the same age and sex, exhibit at least 4 of the following 6 characteristics for frequent and/or prolonged periods of 5 minutes or more.

List those children who over the past 3 to 4 months have been consistently:

1. **Shy** (e.g., watch peers rather than join in, avoid interaction with unfamiliar peers/adults)
2. **Timid** (e.g., avoid initiating interaction or stay apart from peers)
3. **Fearful** (e.g., stop talking and playing when approached by unfamiliar peers/adults or retreat to a quiet area)
4. **Withdrawn** (e.g., are not assertive, lack confidence with peers, seek comfort from mother or familiar adults)
5. **Quiet** (e.g., speak softly and infrequently, need to be helped and encouraged more than other children of their age)
6. **Cautious** (e.g., take a long time to approach, speak to, and play with unfamiliar peers/adults)

First name	1st letter of surname	(Male/Female) please tick
Child 1.....		...../.....
Child 3.....		...../.....
Child 5.....		...../.....
Child 7.....		...../.....

You may have none, one, or more children who fit the above criteria

Part B Date:../../..

Match each of the identified children (called Child 1, 3, 5, or 7 below) as closely as possible with a child (Child 2, 4, 6, or 8 below) who is also:

* in the last term of preschool; and
* of similar age, gender, place in the family, and parental status (e.g., 2 parents, 1 parent).

Rate each pair of children on the statements below on a scale of 1 to 5

(1) rarely (2) sometimes (3) usually (4) frequently (5) always

From your observations of both children over the past 3 to 4 months when:

* in normal preschool situations (e.g., no major disruptions to the day);
* displaying their normal behaviour (e.g., settled, quiet, aggressive);
* on days other than the first day back after term recess, an illness, or lengthy absence; and
* compared to peers of the same age and sex, **do they?**.

(In spaces write 1st names and 1st letter of surnames)	**Child 1**	**Child 2** .....
a. Separate easily from mother/caregiver on arrival	1 2 3 4 5	1 2 3 4 5
b. Initiate interaction with unfamiliar peers/adults	1 2 3 4 5	1 2 3 4 5
c. Seek out and enjoy new activities	1 2 3 4 5	1 2 3 4 5
d. Make peer friendships easily	1 2 3 4 5	1 2 3 4 5
e. Take risks (e.g., climbing, trampolining)	1 2 3 4 5	1 2 3 4 5
f. Take time to approach, speak, and play with peers	1 2 3 4 5	1 2 3 4 5
g. Prefer to play with peers than by themselves	1 2 3 4 5	1 2 3 4 5
h. Become involved in group activities	1 2 3 4 5	1 2 3 4 5
i. Assert themselves in group situations	1 2 3 4 5	1 2 3 4 5
j. Depend on adult support	1 2 3 4 5	1 2 3 4 5
k. Speak confidently in front of peers/adults	1 2 3 4 5	1 2 3 4 5
l. Display confidence in unfamiliar situations	1 2 3 4 5	1 2 3 4 5

How long have you known Child 1 ..years ...months Child 2 ..years ...months

<u>Additional questionnaires are attached</u>

APPENDIX B

Questionnaire B - version 1, Study 1. Version 2, Studies 2 and 3

Please tick the correct answer

As a baby (between 0 and 12 months), was your child

a. In very good health.... had a few problems.... was in poor health....

b. When awake: contented.... a little unsettled.... irritable....

c. When asleep: restful.... a little restless.... fitful....

d. Sleep patterns: regular.... quite regular.... irregular....

e. Eating patterns: regular.... quite regular.... irregular....

f. Response to new foods: adventurous.... hesitant.... refused....

g. When eating, crying, or sucking: not easily distractable.... a little distractable.... easily distractable....

h. Reaction to family members and familiar people: outgoing.... a little cautious.... withdrawn....

i. When approached by strangers: continued playing & vocalising.... stopped but resumed after a while.... stopped & did not resume....

j. In unfamiliar settings: alert.... hesitant.... unhappy....

k. Responded to loud noises with: no concern.... a little concern.... distress....

l. In new situations: explored readily.... took a little time to settle.... stayed close to mother....

m. When separated from mother/caregiver: happy.... took a little time to settle.... unhappy until her/his return....

As a toddler (between 1 year and 2 years 6 months), was your child

a. In very good health.... had a few problems.... was in poor health....

b. When awake: played contentedly.... needed some attention.... needed fairly constant attention....

c. Had afternoon sleeps: every day.... quite regularly.... rarely....

d. Sleep patterns: slept through night.... took some time to settle.... woke during night....

e. Appetite: good.... quite good.... poor....

f. With familiar adults and children: outgoing.... a little cautious .... withdrawn....

g. With unfamiliar adults and children: approached readily.... took time to approach.... retreated from....

h. In new situations would play: a distance away.... quite close to.... very close to.... mother/caregiver

i. When left with grandparent(s), babysitter(s), or other: separated easily.... a little concerned.... unhappy....

<u>At present</u>, is your child

a. In very good health.... has a few problems.... in poor health....

b. Sleep patterns: sleeps through night in own bed.... takes a while to settle.... wakes in night....

c. Appetite: good.... quite good.... poor....

d. With familiar adults and children: interacts readily.... takes a little time to interact.... prefers not to interact....

e. In unfamiliar situations: is at ease quickly.... takes a little while to be at ease.... remains ill at ease....

f. When left with grandparent(s), babysitter(s), or other is: unconcerned.... a little concerned.... quite concerned....

SCHONELL SPECIAL EDUCATION RESEARCH CENTRE

Study of children's reactions to school

Part A

Date of interview:../../..

Interviewer:.....

---

(1) Child's first name:..... 1st letter of surname:....

Birthday:../../.. Male ☐ Female ☐

---

(2) Family make-up

Brothers and sisters: circle which is the child named above, circle M or F for each child, write each child's present age in the box below

Birth order:	1	2	3	4	5	6	7	8	9
Gender: M Male F Female (circle one)	M F	M F	M F	M F	M F	M F	M F	M F	M F
Age:									

Who else lives in the family home (e.g., mother, father, grandparents):

.....

---

(3) <u>As a baby</u> (between 0 and 12 months), was .....

a. In very good health.... had a few problems.... was in poor health....

b. When awake: contented.... a little unsettled.... irritable....

c. When asleep: restful.... a little restless.... fitful....

d. Sleep patterns: regular.... quite regular.... irregular....

e. Eating patterns: regular.... quite regular.... irregular....

f. Response to new foods: adventurous.... hesitant.... refused....

g. When eating, crying, or sucking: not easily distractable.... a little distractable.... easily distractable....

h. Reaction to family members and familiar people: outgoing.... a little cautious.... withdrawn....

i. When approached by strangers: continued playing & vocalising.... stopped but resumed after a while.... stopped & did not resume....

j. In unfamiliar settings: alert.... hesitant.... unhappy....

k. Responded to loud noises with: no concern.... a little concern....

distress....

l. In new situations: explored readily.... took a little time to settle.... stayed close to mother....

m. When separated from mother/caregiver: happy.... took a little time to settle.... unhappy until her/his return....

---

(4) <u>As a toddler</u> (between 1 year and 2 years 6 months), was .....

a. In very good health.... had a few problems.... was in poor health....

b. When awake: played contentedly.... needed some attention.... needed fairly constant attention....

c. Had afternoon sleeps: every day.... quite regularly.... rarely....

d. Sleep patterns: slept through night.... took some time to settle.... woke during night....

e. Appetite: good.... quite good.... poor....

f. With familiar adults and children: outgoing.... a little cautious .... withdrawn....

g. With unfamiliar adults and children: approached readily.... took time to approach.... retreated from....

h. In new situations would play: a distance away.... quite close to.... very close to.... mother/caregiver

i. When left with grandparent(s), babysitter(s), or other: separated easily.... a little concerned.... unhappy....

---

(5) <u>At present</u>, is .....

a. In very good health.... has a few problems.... in poor health....

b. Sleep patterns: sleeps through night in own bed.... takes a while to settle.... wakes in night....

c. Appetite: good.... quite good.... poor....

d. With familiar adults and children: interacts readily.... takes a little time to interact.... prefers not to interact....

e. In unfamiliar situations: is at ease quickly.... takes a little while to be at ease.... remains ill at ease....

f. When left with grandparent(s), babysitter(s), or other is: unconcerned.... a little concerned.... quite concerned....

APPENDIX C

Mothers' questionnaire - Studies 2 and 3

SCHONELL SPECIAL EDUCATION RESEARCH CENTRE

Study of children's reactions to school

Part B

Date of interview:../../..

Interviewer:.....

---

(1) Mother's first name:..... (mother of.....)

1st letter of surname:... Age:.....

Work situation:.....

---

(2) Mother's family

Brothers and sisters: circle mother named above, circle M or F for each brother or sister and write their present age in the box below

Birth order:	1	2	3	4	5	6	7	8	9
Gender: M Male F Female (circle one)	M F	M F	M F	M F	M F	M F	M F	M F	M F
Age:									

a. If living, your parent(s) live in: the same suburb.... the same city.... the same state.... overseas....

b. How often do you see them: once a week.... once a month.... once a year.... less than once a year....

c. If living, your sibling(s) live in: the same suburb.... the same city.... the same state.... interstate.... overseas....

d. How often do you see them: once a week.... once a month.... once a year.... less than once a year....

---

(3) As a child, was <u>your</u>

a. Health: excellent.... good.... had a few problems.... poor....

b. Settled into school: very easily.... quite easily.... had some difficulty.... had quite a degree of difficulty....

c. Related to teachers: very well.... quite well.... had some problems.... not well at all....

d. School attendance: excellent.... regular.... not very regular.... very irregular....

e. School attendance of sibling(s): excellent.... regular.... not very regular.... very irregular....

---

(4) Which behaviour best describes <u>you</u> as a child - rate from 1 to 5

(1) rarely (2) sometimes (3) usually (4) frequently (5) always

Talkative	1	2	3	4	5	outgoing	1	2	3	4	5	happy	1	2	3	4	5
Distractable	1	2	3	4	5	cautious	1	2	3	4	5	obedient	1	2	3	4	5
Risk-taking	1	2	3	4	5	confident	1	2	3	4	5	quiet	1	2	3	4	5

Rate each of the following statements on the same scale

As a child, did <u>you</u>

Separate easily from your mother/caregiver	1	2	3	4	5
Initiate interaction with unfamiliar peers/adults	1	2	3	4	5
Seek out and enjoy new activities	1	2	3	4	5
Make peer friendships easily	1	2	3	4	5
Prefer to play with peers than by yourself	1	2	3	4	5
Become involved in group activities	1	2	3	4	5
Assert yourself in group situations	1	2	3	4	5
Relate well to sibling(s)	1	2	3	4	5
Speak confidently in front of peers/adults	1	2	3	4	5
Become anxious at school	1	2	3	4	5

---

(5) After the birth of your child, was <u>your</u>

a. Health: excellent.... good.... had a few problems.... poor....

b. Were you separated from your child: frequently.... quite frequently... sometimes.... rarely....

c. Was separating: relatively easy.... a little concerning.... difficult..... very difficult....

---

(6) At present, how is <u>your</u>

a. Health: excellent.... good.... having a few problems.... poor....

b. Health of others in your family: excellent.... good.... having a few problems.... poor....

c. How would you describe yourself as a parent - rate from 1 to 5

(1) rarely (2) sometimes (3) usually (4) frequently (5) always

anxious	1 2 3 4 5	encouraging independence	1 2 3 4 5
tolerant	1 2 3 4 5	protective	1 2 3 4 5
caring	1 2 3 4 5	affectionate	1 2 3 4 5
sensitive	1 2 3 4 5		

d. Does your husband/partner share the parenting role (e.g., with discipline, take child to or bring home from preschool/school, take child to after-school/weekend activities): frequently.... usually.... sometimes.... rarely....

e. Compared to your mother's parenting style, is your parenting style: very similar.... quite similar.... different.... very different....

f. Is your relationship with your mother: very close.... quite close.... distant.... very distant....

APPENDIX D

Teachers' questionnaire - Study 2

SCHONELL SPECIAL EDUCATION RESEARCH CENTRE

Study of children's reactions to school

Part A

Date of interview:../../..

Interviewer:.....

---

(1) Child's first name:..... 1st letter of surname:...

Birthday:../../.. Male ☐ Female ☐

---

(2) During the first two weeks of Year 1, has .....

a. Separated from mother/caregiver on arrival at school: easily.... been a little concerned.... been quite anxious.... attempted to follow....

b. Settled into school: very easily.... quite easily.... had some difficulty.... had quite a degree of difficulty....

c. Interacted with you, the teacher: spontaneously.... been quite warm.... a little cautious.... withdrawn....

d. Interacted with peers: spontaneously.... been a little hesitant.... quite hesitant.... isolated him/herself....

e. Initiated friendships with peers: very easily.... quite easily.... had some difficulty.... has not attempted....

f. With unfamiliar adults/peers been: outgoing.... a little cautious.... quite cautious.... retreated from....

g. In new situations: been at ease quickly.... taken a little while to be at ease.... taken quite a while to be at ease.... remained ill at ease....

h. When involved in risk-taking activities (e.g., trampolining, climbing, balancing) been: very confident.... confident.... a little cautious.... very cautious/not attempted....

SCHONELL SPECIAL EDUCATION RESEARCH CENTRE

Study of children's reactions to school

Part B

Date of interview:../../..

Interviewer:.....

---

(1) Child's first name:..... Ist letter of surname:...

Birthday:../../.. Male ☐ Female ☐

---

(2) After the Easter holiday, did .....

a. Still need to be bought to school by mother/caregiver: yes... no...

b. If yes, did he/she: separate easily.... was a little concerned.... was quite anxious.... attempted to follow....

c. Settle back into school: very easily.... quite easily.... had some difficulty.... had quite a degree of difficulty....

d. Interact with you, the teacher: spontaneously.... quite warmly.... a little cautiously.... was withdrawn....

e. Interact with peers: spontaneously.... a little hesitantly.... quite hesitantly.... isolated him/herself....

f. Initiate friendships with peers: very easily.... quite easily.... had some difficulty.... did not attempt....

g. Interact with unfamiliar adults/peers: spontaneously.... a little cautiously.... quite cautiously.... retreat from....

h. Adjust to new situations: quickly.... take a little while to adjust.... take quite a while to adjust.... did not adjust....

i. Involve him/herself in risk-taking activities (e.g., trampolining, climbing, balancing) been: very confidently.... confidently.... a little cautiously.... very cautiously/did not attempt....

SCHONELL SPECIAL EDUCATION RESEARCH CENTRE

Study of children's reactions to school

Part C

Date of interview:../../..

Interviewer:.....

---

(1) Child's first name:..... Ist letter of surname:...

Birthday:../../.. Male ___ Female ___

---

(2) By the end of Semester 1, did .....

a. Still need to be bought to school by mother/caregiver: yes... no...

b. If yes, did he/she: separate easily.... was a little concerned.... was quite anxious.... attempted to follow....

c. Interact with you, the teacher: spontaneously.... quite warmly.... a little cautiously.... was withdrawn....

d. Interact with peers: spontaneously.... a little hesitantly.... quite hesitantly.... isolated him/herself....

e. Initiate friendships with peers: very easily.... quite easily.... had some difficulty.... did not attempt....

f. Adjust to new situations: quickly.... take a little while to adjust.... take quite a while to adjust.... did not adjust....

g. Involve him/herself in risk-taking activities (e.g., trampolining, climbing, balancing): very confidently.... confidently.... a little cautiously.... very cautiously/did not attempt....

h. React to school with anxiety (e.g., complain of stomachaches, headaches): never.... occasionally.... regularly.... often....

i. Was attendance at school: excellent.... regular.... not very regular.... very irregular....

j. Mother/caregiver involved in school activities: very regularly.... regularly.... irregularly.... never....

---

(3) Which behaviour best describes ..... Rate from 1 to 5

(1) rarely (2) sometimes (3) usually (4) frequently (5) always

Talkative	1 2 3 4 5	outgoing	1 2 3 4 5	happy	1 2 3 4 5
Distractable	1 2 3 4 5	cautious	1 2 3 4 5	obedient	1 2 3 4 5
Anxious	1 2 3 4 5	confident	1 2 3 4 5	quiet	1 2 3 4 5

Rate each of the statements below on the same scale. Did .....

Initiate interaction with unfamiliar peers/adults	1 2 3 4 5
Seek out and enjoy new activities	1 2 3 4 5
Take time to approach, speak to, and play with peers	1 2 3 4 5
Interact readily with familiar adults and peers	1 2 3 4 5
Prefer to play with peers than by him/herself	1 2 3 4 5
Make peer friendships easily	1 2 3 4 5
Become involved in group activities	1 2 3 4 5
Assert him/herself in group situations	1 2 3 4 5
Depend on adult support	1 2 3 4 5
Speak confidently in front of peers/adults	1 2 3 4 5
Display confidence in unfamiliar situations	1 2 3 4 5

APPENDIX E

Letters outlining study - CYMHS clinics

UNIVERSITY OF QUEENSLAND LETTERHEAD

To the Child and Youth Mental Health Service:

.....

We are conducting a study through the Schonell Special Education Research Centre, The University of Queensland, on the way in which children make the transition from home to school. Part of the study will focus on children who have been attending school for a number of years but who may have had school adjustment problems in the past. We would appreciate the help of your clinic in identifying children who have been treated for problems with school attendance/school refusal/school phobia in the past 4 years.

Permission for the study has been given by the Queensland Education Department, the Queensland Health Department, and the Brisbane Catholic Education Centre. Should an identified child attend an independent school, permission will be sought from the appropriate authority.
Mothers/caregivers of all identified children will be contacted and their consent obtained for participation in the study. Strict confidentiality will be maintained at all times. We will be happy to feed back further information to you about the study and the results at the end of 1997. If you have any questions, you can contact Julia on 3253 7458 (work) or 3300 5820 (home), however, we will make contact with you in the week of .....

Thank you for your help
Sincerely

Adrian F. Ashman

Director
Schonell Special Education
Research Centre
The University of Queensland

Julia Murphy

Liaison Teacher
State Special School
Royal Children's Hospital
Brisbane

QUEENSLAND HEALTH LETTERHEAD

Dear .....

As the person coordinating your child's care at this clinic I am writing to let you know about a research project that you may be interested in taking part in. No personal details, names or addresses have been provided to the researcher - your participation can only proceed if you complete and return the attached consent form to the researcher.

The attached letter from the Schonell Special Education Centre, The University of Queensland, outlines the study, however, if you have any further questions you can contact the researcher, Julia Murphy on 3253 7458 (work) or 3300 5820 (home), or myself on 3253 7878 (work).

The Schonell Centre has assured us that confidentiality will be maintained at all times. Schools will not be informed of how, or why, children were chosen for the study. Their teachers, however, will be asked to complete a questionnaire on their school functioning. Children will not be observed in the school setting by the researcher nor will they be contacted by the researcher in any way.

The Royal Children's Hospital Ethics Committee has been fully informed of the study and has given it their approval. This clinic has also been fully informed of the study and of the approval given by the Ethics Committee.

Your participation or non-participation, in the study will not affect your child's ongoing treatment at this clinic.

Sincerely

.....

Psychologist/Social Worker/Registrar
Child and Family Therapy Unit

APPENDIX F

Consent forms

SCHONELL SPECIAL EDUCATION RESEARCH CENTRE
THE UNIVERSITY OF QUEENSLAND

Study of Children's Reactions to School

Consent Form

I, ... (name of mother/caregiver) have been informed about this study and have been given the opportunity to ask questions about it.

I agree to take part in the study. I understand that what I say will be kept strictly confidential and in no way will any member of my family be identified. I also give permission for the teacher of my child to take part in the study.

I understand that information will be gathered by means of questionnaires and all questionnaires will be destroyed at the end of the study. I also understand that I can withdraw from the study at any time without affecting my relationship with the University of Queensland.

Participant

Signature ..... Date:../../....
mother/caregiver (circle which is appropriate)

Interviewer

I, the undersigned, have fully explained the relevant details of this study to the participant named above.

Signature ..... Date:../../...

Name (print)..... Telephone.....

In you are willing to be part of the study could you please write your address and phone number below so that I can contact you.

Address .....

.....

.....

Telephone .....

APPENDIX G

Teachers' questionnaire - Study 3

SCHONELL SPECIAL EDUCATION RESEARCH CENTRE

Study of children's reactions to school

Date of interview:../../..

Interviewer:.....

---

(1) Child's first name:..... Ist letter of surname:...

Birthday:../../.. Male ☐ Female ☐

---

(2) When interacting socially, does .....

a. Interact with you, the teacher: spontaneously.... quite warmly.... a little cautiously.... is withdrawn....

b. Interact with peers: spontaneously.... a little hesitantly.... quite hesitantly.... isolates him/herself....

c. Initiate friendships with peers: very easily.... quite easily.... has some difficulty.... never attempts....

d. With unfamiliar adults/peers appear: outgoing.... a little cautious.... quite cautious.... retreats from....

e. In new situations appear: at ease quickly.... takes a little while to be at ease.... takes quite a while to be at ease.... remains ill at ease....

f. When involved in risk-taking activities (e.g., trampolining, climbing, balancing) appear: very confident.... confident.... a little cautious.... very cautious/does not attempt....

---

(3) .....'s school behaviours

a. Settled into school this year: very easily.... quite easily.... had some difficulty.... had quite a degree of difficulty....

b. Comes to school with: parent(s).... sibling(s).... peer(s).... alone....

c. If comes with parent(s): separates easily.... is a little concerned.... is quite anxious.... attempts to follow....

d. School attendance is: excellent.... regular.... not very regular.... very irregular....

e. Shows signs of anxiety (e.g., complains of stomachaches, headaches): never.... occasionally.... regularly.... often....

f. Mother/caregiver is involved in school activities: very regularly.... regularly.... irregularly.... never....

(4) Which behaviour best describes ..... Rate from 1 to 5

(1) rarely (2) sometimes (3) usually (4) frequently (5) always

Talkative 1 2 3 4 5	outgoing 1 2 3 4 5	happy 1 2 3 4 5
Distractable 1 2 3 4 5	cautious 1 2 3 4 5	obedient 1 2 3 4 5
Anxious 1 2 3 4 5	confident 1 2 3 4 5	quiet 1 2 3 4 5

Rate each of the statements below on the same scale. Does .....

Initiate interaction with unfamiliar peers/adults	1 2 3 4 5
Seek out and enjoy new activities	1 2 3 4 5
Take time to approach, speak to, and play with peers	1 2 3 4 5
Interact readily with familiar adults and peers	1 2 3 4 5
Prefer to play with peers than by him/herself	1 2 3 4 5
Make peer friendships easily	1 2 3 4 5
Become involved in group activities	1 2 3 4 5
Assert him/herself in group situations	1 2 3 4 5
Depend on adult support	1 2 3 4 5
Speak confidently in front of peers/adults	1 2 3 4 5
Display confidence in unfamiliar situations	1 2 3 4 5

APPENDIX H

Characteristics of former school refusal children/adolescents

Appendix H

Characteristics of Former School Refusal Children/Adolescents

	Daniel	Paul	Darren	Leon	Nathan	Eric
Academic achievement/ functioning	received learning support	below average in language areas	below average repeated a grade	dependent on teacher for social & academic support	below average but average/ high IQ	above average in all curriculum areas
Children in family/place	4 youngest	4 youngest	2 eldest	1 only	3 youngest	3 youngest
Age at presentation	7 years	9 years	10 years	11 years	11 years	9 years
Gender	male	male	male	male	male	male

APPENDIX I

Early history of former school refusal children/adolescents

Appendix 1

Early History of Former School Refusal Children/Adolescents

As Baby	Daniel	Paul	Darren	Leon	Nathan	Eric
Health	reflux	good	colic	infections	reflux	good
During day	unsettled	unsettled	unsettled	unsettled	contented	contented
During night	unsettled	woke	woke	unsettled	woke	settled
Eating patterns	irregular/ refused new foods	irregular/ refused new foods	regular/ poor appetite	regular/ enjoyed new foods	regular	irregular/ fussy with new foods
When eating	distracted	settled	distracted	settled	distracted	distracted
With family and friends	cautious	cautious	hesitant	quite outgoing	outgoing	cautious
With strangers	clung to mother	stayed close to mother	stopped playing/ vocalising	clung to mother	hesitant	clung to mother
Left with babysitters	maternal grandmother	rarely left	only maternal grandparents	only mother's family	only maternal grandmother	only father
Response to babysitters	unhappy/ cried	unhappy/ cried	unhappy/ cried	unhappy/ cried	unhappy/ cried	unhappy/ cried
As Toddler						
Health	asthma	good	asthma	infections	ear problems	good
During day	demanded mother's time	stayed close to mother	wanted mother's attention	stayed close to mother	contented	contented
During night	took time to settle	woke	woke	slept with parents	'woke	settled
With strangers	retreated from	withdrawn	took time to approach	wary	took time to approach	cautious
With babysitters	unhappy	unhappy	upset/didn't settle	unhappy/ cried	unhappy	upset/ unsettled

APPENDIX J

School refusal history and present school functioning of former school refusal children/adolescents

Appendix J

School Refusal History and Present School Functioning of Former School Refusal Children/Adolescents

History	Daniel	Paul	Darren	Leon	Nathan	Eric
At preschool	clung to mother	clung to mother	didn't attend/ too upset	often tried to follow mother	refused to stay/very upset	separated easily
In Year One	1st 4 weeks held by teacher when mother left	1st 4-5 weeks clung to mother	cried/ hesitant all year	often held by teacher when mother left	difficulty separating from mother	separated easily
School attendance	always irregular	always irregular	always irregular	always irregular	always irregular	regular 1st 2 years
Presented at	CFTU in Year 3	CFTU in Year 4	CFTU in Year 4	CYMHS in Year 7	CFTU in Year 6	CFTU in Year 4
Length of stay/ treatment	4 weeks	5 weeks	6 weeks	out-patient 5 weeks	6 weeks	5 weeks
Further admissions/ treatment	5 (1 night only) over 5 years	in-patient follow-up	4 weeks & 4 (3-4 days) over 7 years	on contract with therapist	7 (1-7 days) over 3 years	7 (2-3 days) over 3 years
At present						
Attending school	Distance Education	yes	no	yes	no	yes
Attendance	---	regular	---	regular	---	regular
With peers	---	hesitant	---	cautious	---	hesitant
With teachers	---	cautious	---	cautious	---	cautious
Anxious	---	yes	---	yes	---	no
Dependent on adult support	---	in social situations	---	socially & academically	---	no

APPENDIX K

Present home and social functioning of former school refusal children/adolescents

Appendix K

Present Home and Social Functioning of Former School Refusal Children/Adolescents

Behaviours	Daniel	Paul	Darren	Leon	Nathan	Eric
With peers	no friends of own age	hesitant at times	no friends of own age	hesitant	has friends	still hesitant at times
With family/ friends	prefers not to interact	takes time to interact	takes time to interact	takes time to interact	interacts readily if likes them	interacts readily
With strangers	hesitant/ ill at ease	cautious/ ill at ease	prefers not to interact	cautious/ ill at ease	prefers not to interact	cautious
In unfamiliar situations	very cautious	ill at ease	never at ease	hesitant	hesitant	ill at ease
Sleep patterns	takes time to settle settle	no longer has problems	no longer has problems	wakes 2-3 times a week goes into parent's room	no longer problems	no longer problems
Separating from mother	still anxious	concerned at times	concerned at times	still having some trouble	concerned at times	concerned

APPENDIX L

Mothers of former school refusal children/adolescents, their past and present functioning

Appendix L

Mothers of Former School Refusal Children/Adolescents, their Past and Present Functioning

School history	Teresa	Olivia	Mary	Wendy	Fran	Claudine
Reaction to school	anxious about achieving	quiet/ cautious	anxious/ cautious	no self-confidence/ low self-esteem	lonely/ unhappy	quiet/ timid
Attendance	regular but difficulty settling	regular from Year 3 onwards	regular but difficulty settling	irregular from Year 3 onwards	regular/ enjoyed school	regular/ liked school
Peer relationships	quiet/ few friends	difficulty making friends	only a few friends	very shy	very few friends	didn't make friends easily
Recent history/ parenting style						
Anxious about	Daniel's isolation	Paul living with father	Darren's future	being lonely when Leon older	Nathan's activities	having her own life
Separating from child	still concerned	still concerned	still concerned	still concerned	still concerned	still anxious
Own mother's parenting style	loving/caring but always at work	anxious/ overprotective	strict	very strict/ not openly affectionate	very haphazard	threatened but didn't act
Own parenting style	tolerant/ caring, home with children	similar to mother's	not as strict	quite different more casual/ affectionate	very different spent more time with children	similar but stricter
Relationship with mother	very close	quite close	very close	very close	love-hate relationship	close
Family parenting roles	father rarely involved	father only involved	father never involved	father very involved	father never involved	father never involved

APPENDIX M

Letters to psychiatrists and therapists, preschool teachers, mothers (Studies 1 and 2) and principals (Studies 1 and 2)

UNIVERSITY OF QUEENSLAND LETTERHEAD

Dear.....

We are conducting a study through the Schonell Special Education Research Centre, The University of Queensland, on separation anxiety in school refusal. We would appreciate your comments and/or suggested amendments to the enclosed questionnaire about:

* issues which may not be adequately addressed;
* awkward and/or inappropriate wording; and
* lack of clarity or purpose for items listed.

The questionnaire is to be forwarded to preschool teachers in the Brisbane area as a screening device for behaviourally inhibited and uninhibited children. It has been developed from data from the Harvard Infant Study Laboratory.

Researchers from the Laboratory have suggested that behavioural inhibition is a precursor to separation anxiety. It can be identified in children before they are 2 years of age while separation anxiety is not identifiable until children are older (generally school age).

Given that behavioural inhibition can be identified much earlier than separation anxiety, it may be possible to identify behaviourally inhibited children during their preschool years and monitor their transition to school. The aim of the study is to determine whether children identified as behaviourally inhibited during the preschool years are (a) at-risk for separation anxiety/school refusal, and (b) preventative measures can be instituted during the preschool and early school years to ease and/or prevent future school adjustment problems.

We intend to identify behaviourally inhibited children in their last term of preschool, match them with uninhibited children of the same age, gender, birth order position, and parental status and follow the progress of both groups through to the end of Semester 1 of Grade 1.

Thank you for your cooperation,
Sincerely

Adrian F. Ashman

Director
Schonell Special Education
Research Centre
The University of Queensland

Julia Murphy

Liaison Teacher
State Special School
Royal Children's Hospital
Brisbane

UNIVERSITY OF QUEENSLAND LETTERHEAD

To the Preschool Teacher(s), ... Preschool

We are conducting a study through the Schonell Special Education Research Centre, The University of Queensland, on the way in which children make the transition from home to school. We would appreciate your help in identifying children (using a very simple form) in their last term of preschool who could be monitored from the beginning to the end of the 1st semester of 1997 to assess their school adjustment.

As you will be aware, some children make the home-school transition very readily while others have difficulty breaking the routine of home life and establishing regular school attendance patterns. We know some of the reasons for difficult and easy transitions and this study addresses the way in which parents can assist in this process while the child is at preschool and when he/she enters Grade 1.

The questionnaire consists of 2 parts (2 pages in total) to be filled in during Term 4 of this year. We will be happy to feed back further information about the study and the results at the end of 1997. If you have any questions, you can contact Julia on 3253 7458 (work) or 3300 5820 (home), however, we will make contact with you in the week of.....

Permission for the study has been given by the Queensland Education Department, the Queensland Health Department, the Brisbane Catholic Education Centre, and individual preschools. Permission will be sought from the parents of all identified children and all information gathered will be confidential.

Thank you for your help
Sincerely

Adrian F. Ashman

Director
Schonell Special Education
Research Centre
The University of Queensland

Julia Murphy

Liaison Teacher
State Special School
Royal Children's Hospital
Brisbane

UNIVERSITY OF QUEENSLAND LETTERHEAD

Dear.....

We are conducting a study on children's reactions to experiences in their school years. We would like to monitor the reactions of a number of children attending your child's preschool through to the end of Semester 1 of Year 1, 1997. We would appreciate your help in this study and hope that you will agree to take part.

The purpose of the study is to identify ways in which children can be helped to make the transition between home and school more easily than many do now.

If you are happy to participate, your involvement will consist only of answering a two-part questionnaire. In Part A the questions are about your child's behaviour as a baby, a toddler, and at the present time. In Part B the questions are about your reactions to school, motherhood, and the general health of you and your family.

The staff at the preschool your child attends has agreed to be part of the study and the study has been approved by the Queensland Education Department, the Queensland Health Department, the Brisbane Catholic Education Centre, and individual independent schools and preschools. If you are willing to take part in the study, the school your child will attend in 1997 will be contacted and informed of your decision. Permission will be sought for the school's participation also. All information gathered will be confidential and neither you nor any member of your family will be identified as participants. We will be happy to feed back general information to you at the end of the study. If you have any questions, you can contact Julia on 3253 7458 (work) and 3300 5820 (home).

Could you please sign the attached consent form and return it in the reply paid envelope if you are willing to participate in the study. We will then forward the questionnaire to you and make telephone contact in the week of .....

Thank you for your help
Sincerely

Adrian F. Ashman

Director
Schonell Special Education
Research Centre
The University of Queensland

Julia Murphy

Liaison Teacher
State Special School
Royal Children's Hospital
Brisbane

UNIVERSITY OF QUEENSLAND LETTERHEAD

Dear.....

We are conducting a study on children's reactions to experiences in their school years. We would appreciate your help in the study and hope that you will agree to take part. The purpose of the study is to identify ways in which children can be helped to make the transition between home and school more easily than many do now. We would like to monitor children who have attended school for some years to assess their present reactions to school and their reactions in the past.

If you are happy to participate, your involvement will consist only of answering a two-part questionnaire. In Part A the questions are about your child's behaviour as a baby, a toddler, and at the present time. In Part B the questions are about your reactions to school, motherhood, and the general health of you and your family.

Permission for the study has been given by the Queensland Education Department, the Queensland Health Department, the Brisbane Catholic Education Centre, and individual independent schools. If you are willing to take part in the study, the school your child attends will be contacted and informed of your decision. Permission will be sought for the school's participation also. All information gathered will be confidential and neither you nor any member of your family will be identified in the final report. We will be happy to feed back general information to you at the end of the study. If you have any questions, you can contact Julia on 3253 7458 (work) or 3300 5820 (home).

Could you please sign the attached consent form and return it in the reply paid envelope if you are willing to participate in the study. We will then forward the questionnaire to you and make telephone contact.

Thank you for your help
Sincerely

Adrian F. Ashman

Director
Schonell Special Education
Research Centre
The University of Queensland

Julia Murphy

Liaison Teacher
State Special School
Royal Children's Hospital
Brisbane

UNIVERSITY OF QUEENSLAND LETTERHEAD

To the Principal .....

We are conducting a study through the Schonell Special Education Research Centre, The University of Queensland, on the way in which children make the transition from home to school. As you will be aware, some children make the home-school transition very readily while others have difficulty breaking the routine of home life and establishing regular school attendance patterns. We know some of the reasons for difficult and easy transitions and this study addresses the way in which parents can assist in this process while the child is at preschool and when he/she enters Grade 1.

We would appreciate the help of Year 1 teachers at your school in distributing questionnaires (30 in total) to mothers of Year 1 students and returning them in the self-addressed stamped envelopes to the researchers. The questionnaires are trial questionnaires only - their purpose is to gauge the way in which mothers will respond to particular questions, whether relevant issues have been adequately addressed, and whether awkward or inappropriate wording has been used. No names are required on the questionnaires so that both the mothers' and children's identities will remain unknown to the researchers and, therefore, confidentiality strictly maintained.

Permission for the study has been given by the Queensland Education Department and Ethical Clearance from the Department is included with this letter. If you have any questions you can contact Julia on 3253 7458 (work) or 3300 5820 (home). We will be happy to feed back further information to you about the study and the results at the end of 1997.

Thank you for your help
Sincerely

Adrian F. Ashman

Director
Schonell Special Education
Research Centre
The University of Queensland

Julia Murphy

Liaison Teacher
State Special School
Royal Children's Hospital
Brisbane

UNIVERSITY OF QUEENSLAND LETTERHEAD

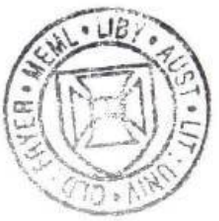
To the Principal of .....

We are conducting a study through the Schonell Special Education Research Centre, The University of Queensland, on the way in which children make the transition from home to school. As you will be aware, some children make the home-school transition very readily while others have difficulty breaking the routine of home life and establishing regular school attendance patterns. We know some of the reasons for difficult and easy transitions and this study addresses the way in which parents can assist in this process while the child is at preschool and when he/she enters Grade 1.

We would appreciate the help of Year 1 teacher(s) at your school in briefly assessing a small number of children during the 1st semester of 1997. Could teachers please complete a questionnaire consisting of 3 parts. Part A is to be filled in during the first 2 weeks of Term 1, Part B after the Easter break, and Part C at the end of Semester 1. We will be happy to feed back further information to you about the study and the results at the end of 1997. If you have any questions, you can contact Julia on 3253 7458 (work) or 3300 5820 (home), however, we will make contact with you in the week of.....

Permission for the study has been given by the Queensland Education Department, the Queensland Health Department, the Brisbane Catholic Education Centre, and all individual independent schools involved. The mothers of all children have agreed to participate in the study and have given permission for teachers to be contacted. All information gathered will be confidential.

Thank you for your help
Sincerely



Adrian F. Ashman

Director
Schonell Special Education
Research Centre
The University of Queensland

Julia Murphy

Liaison Teacher
State Special School
Royal Children's Hospital
Brisbane

Child/children to monitored:

....